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THE NATURE OF SOCIAL ACCOUNTABILITY IN SOUTH AFRICAN MEDICAL PRACTICE AND EDUCATION – A QUALITATIVE REFLECTION

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A thesis submitted to the Faculty of Health Sciences,
University of the Witwatersrand, Johannesburg,
in fulfilment of the requirements for the degree of
Doctor of Philosophy

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Declaration

I, Lionel Green-Thompson, declare that this thesis is my own work. It is being submitted for the degree of Doctor of Philosophy in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

……

L.P. Green-Thompson

…… October, 2014

To my father and mother,

Hugh James Green-Thompson

4 October 1922 – 13 February 1990

The first expression of social accountability in my life.

Small town doctor, civic advocate and part-time farmer

and

Katherine Regina Green-Thompson

5 June 1932 –

The first reflection of faith in social action in my life.

Presentations arising from this study

Social Accountability – hearing community voices

> 6th National Conference 2013, South African Association of Health Educationalists (SAAHE), Durban, South Africa

Social Accountability – hearing community voices

> Annual Congress 2013, Association of Medical Education of Europe, Prague, Czech Republic

Two abstracts accepted for presentation at 2014 The Muster: Global Community Engaged Medical Education in Uluru, Northern Territories, Australia titled:

> Learning ***with*** community – students' reflections on social accountability after community experiences
>
> Taking social accountability forward – a proposed framework

Abstract

Social accountability describes the extent to which a medical education institution's research, service and education make a difference to the health status of the community in which they work. An individual practitioner is expected to attain a range of graduate attributes and competencies many of which enable a responsive approach to practice in society.

This qualitative study in the grounded theory tradition explored the notion of social accountability from the perspectives of three stakeholders: 81 members of the *community* participated in eight focus groups held in Mpumalanga, North West and Gauteng, South Africa between November 2012 and August 2013; final year *medical students* participated in eleven focus group discussions at the end of 2012 (25 students) and 2013 (70 students) and *education partners* (12 academics, three health-system managers and an insurance manager) participated in in-depth interviews between June and October 2013.

A conceptual model emerged from the data for each stakeholder group:

- An ubuntu framing of social accountability which centralised a community of reciprocal relationships at a village or township level. These relationships were described as reflecting the tension between the vulnerability of the patient and the power vested in the doctor.
- The vision of students. Students valued guided reflection in nurturing educating communities where intimacy with their teachers would help to build a wider view of the complex systems of health. Their vision is cast as a series of catalysts and detractors which influence their education.
- The road to health. The partners' aspirations for their students defined a transformed professional milieu in which the graduate is able to look beyond the single patient to the health of a community.

In conclusion, the study proposes a *Framework for the Advancement of Social Accountability* which takes into account the complexity of the systems of health care and health sciences education. This framework makes ten proposal statements which may be grouped in three domains: the central role of the community, relationships and an empowered faculty community. The understanding of the social determinants of health must form a part of the engagement with communities and facilitate their involvement in the curriculum. There is recognition of the importance of nurturing relationships amongst all of the stakeholders in health care delivery. These relationships need to be developed in education communities as well as in relation to learning in communities. In order for a health professions faculty to make an impact on the care of a nation, the community within it must be developed to drive the needed changes for improved health.

Keywords: social accountability, complexity thinking, reflective practice, ubuntu, curriculum

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Abbreviations, acronyms and glossary

CanMeds	Statement of competencies declared by Royal College of Physicians and Surgeons of Canada
Community	Area in which medical students spend at least two weeks of their training time
CPU	Conceptualisation – Production – Usability model
Faculty Development	Programme adopted to train staff for their educational role
IPC	Integrated Primary Care clinical clerkship in final year medicine
MBBCh	Bachelor of Medicine and Bachelor of Surgery degree used to describe medicine qualification at University of the Witwatersrand
MDG	Millennium Development Goals
NDP	National Development Plan
NHLS	National Health Laboratory Services
Rural Community	Community which is further than two hours driving time away from Johannesburg campus
Staff	People employed for the education of students. These may

	be fully employed by the university or jointly employed with a government agency in the health care system
Urban community	Community located within the Johannesburg metropolitan city
Wits	University of the Witwatersrand

My personal statement

I graduated from the University of the Witwatersrand in 1988. At the end of that year, I participated in an alternative graduation ceremony as a final objection to the role played by Wits as a liberal higher education institution in relation to apartheid as the prevailing political system in the country. The university held a special graduation in 2005 to acknowledge all graduates who had taken similar decisions during the eighties.

I was admitted to Wits directly from secondary school having been subject to special consents at both these levels of education. In order to attend an "Asian"[1] secondary school as a "Coloured" youngster, consent was required from the administration for schools. Then in 1981, consent was obtained from the National Department of Education to attend Wits in 1982 as a person of colour as part of the quota system in use at the time. While at the university I became active in the student politics of the day representing black students in their engagements with the faculty as well as mobilizing students in protest action against the oppressive apartheid system of government which prevailed.

These experiences have coloured my journey through Wits University as a student and contributed to a view of my medical education from the underside despite my middle class upbringing as the son of a country doctor.

I am a specialist anaesthesiologist who has been employed full time in a Centre for Health Science Education. This results in the constant tension of how socially accountable it is to practice as an educator despite having been trained in a skill which is relatively scarce in the national health landscape.

The PhD journey which is represented by this thesis has been made possible through the Wits Carnegie Clinical PhD Fellowship. It has provided a reflective space

[1] Asian and Coloured were descriptions for people of Indian descent and those who were of mixed race in the racial classification of South Africans in the Population Registration Act under the apartheid system.

and these are recorded either as audio or written pieces over the two year duration of this study. I have learnt that *relationships between good health and the health system are mediated by health care workers or professionals. This mediation must be located in community mobilisation and empowerment* (2013.09.20)[2]. In this regard I have been challenged by the notion of health as *political* (2013.09.25), but also by the call for graduates to emerge with a certain level of *political consciousness* (2013.09.20). The political framing of health brings our identification of the community into the foreground as the space in which what we teach is vivified. The community, I now understand, is seen differently depending on one's perspective and the context in which one engages with community. For many communities, *social justice* remains a significant task (2013.08.20).

I have come to appreciate the community as a place in which to create a nurturing learning environment where students learn to live with uncertainty and, through this, develop resilience (2013.09.09).

I believe that we need to shift our health care endeavour from one based in illness to one in which the wellness of the community is centralised and society is able to flourish (2013.10.16).

My world view is, therefore, framed by three dimensions:

- Health care and its inequitable distribution remain an important marker of the state of our nation and its ability to care for the marginalised communities who experience poverty and its manifold effects;
- Health professionals through their status in society have an important role in acting with a sense of real altruism in delivering care to our people and in advocacy to achieve an equitable distribution of resources in the societies in which we live;
- The education of health care professionals must focus on the well being of communities rather than their disease.

[2] Italics represent direct quotations from reflective notes written during the study. The dates in parentheses are the dates on which these reflections were written. In the case of a date appearing without a quotation, the original reflection has been paraphrased

I approached this research project with a commitment to change the social dynamics of medicine and health care in general which has resonance in the Lancet Commission Report of 2010 (Frenk et al., 2010). Mehrtens describes this transformative world view as being one which engages with marginalised groups of people with intent to change their social conditions (Creswell, 2014; Mertens, 2010).

I am committed to the establishment of truly socially accountable educational institutions (as defined by Boelen and Heck, 1995) made up of socially accountable professionals.

Chapter 1:
Introduction to the Study

1.1 Background

Social accountability, as defined by the World Health Organisation (WHO), is an orientation which directs medical education institutions to use their research, service and education processes to address the health priorities of marginalized communities (Boelen and Heck, 1995).

The priority health concerns which are referred to in the definition above are reflected in the ongoing crisis in global health with great inequities between the richer and poorer nations (Frenk et al., 2010). The WHO has set targets in the form of the Millennium Development Goals (MDG) which should be achieved by 2015 (United Nations Development Programme, 2000). Some of these MDGs are located squarely in the delivery of health care referring to the control of infectious diseases and the health of mothers and children. Other goals deal with social transformation through the assurance of primary education, the elimination of poverty and the improvement of the plight of women through empowerment. One of these goals is the establishment of a global movement in the interest of development for all nations through global cooperation (United Nations Development Programme, 2000). The concerns which are targeted in this goal setting approach are part of the South African landscape as well.

South Africa has inherited a dysfunctional health system from a long history of discrimination (Coovadia et al., 2009). This legacy has led to significant challenges for the post apartheid government in addressing these health inequities. The Lancet series on health in South Africa in 2009 reflected on the quadruple burden of disease which pervades the health system in the country leading in some instances to the reversal of achievements in the quest for the Millennium Development goals for 2015 (Chopra et al., 2009). As a result of this quadruple burden of disease, many of the inequities in health care access persist and the sense is that a response would need to broaden the breadth and depth of access

(Harris et al., 2011). In proposing solutions to the many challenges, Chopra et al. (2009), have raised the idea of a different view of leadership in the health sector. Their proposed vision of the future highlights the notions of inclusive leadership and accountability to communities which should be a characteristic of those people engaged in delivering service at all levels of the health system. Harris et al (2013) place these ideas within a context of restorative health which implies the restoration of a just health paradigm in a time of transition such as that which characterises the South African health system at this time. Their study from the perspective of people at 'street level' suggests that health as a site of a struggle for justice may be an important site for the encouragement of changed power dynamics within the patient – provider relationships (Harris et al., 2013). The accountability between the provider and patient renews the idea of a social contract implicit in any accountable relationship bringing the parties closer together (Harris et al., 2014).

Mayosi et al. (2012), in their update of the 2009 Lancet series, reflect on some of the advances made in the South African health system. The authors acknowledge that the renewal of senior leadership has driven many of the positive developments seen in the public health sector. However, they assert that appropriate leadership must be pervasive at all levels of the health care system (Mayosi et al., 2012).

The South African National Development Plan (NDP) has charted a course for the ongoing development of South Africa which addresses the promotion and maintenance of health for all the people (National Planning Commission, 2011). The key proposals in the area of health address the social determinants of health, reduction of the disease burden, strengthening the health system, implementing a National Health Insurance System and building human resources (National Planning Commission, 2011). The NDP calls for an increased emphasis on community based care by an increased number of health care professionals who demonstrate, amongst other competencies, an enhanced ability to manage their work space and work within intersectoral teams (National Planning Commission, 2011).

With this background, there should be an increased awareness of the call to educational institutions to revise their curricula and review the programmes which are offered for educating health professionals which allows them to perform appropriately in a wide range of contexts (Chopra et al., 2009).

This idea of a transformed learning environment has formed part of the ongoing argument for a transformative education for health professionals (Frenk et al., 2010; Celletti et al., 2011). The Lancet Commission, reflecting on a hundred years since Flexner transformed the medical education of his day, make the call for a transformative education paradigm which has as its goal the production of health professionals who are both competent and socially responsive. The responsibility for this is placed on the educational institutions that should become socially accountable (Woollard and Boelen, 2012).

The growing concerns regarding the impact of educational institutions have resulted in calls for such education to be focused on the WHO principles of health systems becoming relevant, effective, of high quality and accessible (Boelen and Woollard, 2009). However, the challenges of translating educational interventions into concrete results are recognized (Frank and Danoff, 2007). Boelen and Woollard (2009) developed a method to assist institutions to reflect on their social accountability through conceptualization – production – usability (CPU). They argue that this model allows for the alignment of the visions and values of a conceptualization phase with the constructs of the production of a graduate. This graduate will ultimately be retained in the areas of greatest need in that community making an impact on the health of the people (Boelen and Woollard, 2009).

The CPU model is given further clarity through the evaluation framework proposed by THENet (The Training for Health Equity Network, 2011). The framework translates the proposed CPU model into detailed practical guidelines which can be evaluated. The conceptualization construct becomes the question of how an institution works, production becomes what an institution does and usability translates into the crucial question of “what difference do we make?”.

Both the CPU model and the Evaluation Framework emphasise the employment destination or the degree of retention of graduates in the communities which their

educational institution is “mandated to serve” (Boelen and Heck, 1995; Boelen and Woollard, 2009; Woollard and Boelen, 2012; The Training for Health Equity Network, 2011).

Little detail is given regarding the nature of the practitioner which comes out of the socially accountable institution or what the nature of a “change agent” is (Frenk et al., 2010). Frenk et al. (2010) describe the transformative education agenda as using a competency based system to produce a graduate who is competent and able to serve the needs of a community. The idea of a competency based medical curriculum has grown recently with the seven dimensions of a physician best expressed by the CanMEDS competencies. These roles being those of the medical expert, communicator, collaborator, manager, health advocate, scholar and professional (Frank and Danoff, 2007; Frank, 2005). I would argue that the two competencies which may be the most important in the nature of a socially accountable medical practitioner are those of the health advocate and professional. The CanMEDS framework defines professionalism as a commitment to patients, profession and society as well as sustainable practice. This professionalism is given additional activism through the definition of advocacy which recognizes responsiveness to the needs of the community as a key feature (Frank and Danoff, 2007). The Physician’s Charter of professionalism goes further to regard action for social justice as an integral part of medical professionalism (Medical Professionalism Project, 2002).

The international movement towards a competency based medical education approach was echoed in South Africa as the country began its transition into a democracy (Zwi et al., 1994). All of the undergraduate medical programmes undertook major revisions over the last decade, moving towards core curricula with newer instruction designs, including problem based learning and a deepening community based experience for medical students (Seggie, 2010). The medical (MBBCh) curriculum at the University of the Witwatersrand (Wits) was part of this national transformative movement and a revised curriculum was launched in 2003. The initial curriculum development modified the last four years of the six year MBBCh degree to facilitate the entry of graduates at the third year of study. This cohort of students joined those who had entered the first year of the programme

directly from school. The curriculum is based on four themes which guide the students' learning through years three to six. At the end of these six years students graduate and enter a two year preregistration internship. The themes of the curriculum are basic clinical sciences, community – doctor, patient – doctor and personal and professional development. The introduction of problem based learning as the central instructional design of years three and four of the programme was the flagship transformation. Years five and six are committed to clerkships through the clinical disciplines on a rotational basis. The foundational tenet for the revised curriculum was a commitment to four global competencies: the ability to provide comprehensive patient care in a plurality of health and social contexts both acutely and beyond the immediate consultation, cultural and social competency as well as the competency to assess needs and provide effective care to a geographically defined community. This curriculum and the stakeholders engaged in its delivery, form the context for this study.

1.2 Problem Statement

Social accountability is an integral part of a transformative medical education system which seeks to educate doctors who are responsive to needs of the communities in which they serve (Frenk et al., 2010). In South Africa, the emerging health system requires a doctor who has competencies which match the complex demands of achieving a long and healthy life for all (National Planning Commission, 2011; Chopra et al., 2009). The medical education system in South Africa has reflected positively on both the need for adopting new strategies for education as well as on the major international developments which have supported these in recent decades (Zwi et al., 1994; Seggie, 2010).

South Africa will need a different kind of professional at a street level in order to effect a changed context for health care delivery (Harris, 2011). There are no data which examine the issue of social accountability from the perspectives of communities, students and partners (academic and service) in the education of doctors or in terms of their expectations of doctors. This study addresses this gap and offers an opportunity to articulate a framework for the advancement of social accountability in medical education in a local institution which can be translated to the national and international context.

1.3 Significance of the Study

This study is important because it addressed the theme of the broader competencies which graduating medical personnel should attain. It allowed communities to express themselves in regard to the conduct of doctors as well as their relationships with universities. Students discussed what it means to be socially accountable and how they may achieve that competency. This study is the first opportunity for the partners in the education of doctors to express their aspirations for the graduates of medicine as they emerge from university into the health system. The provision of health care professionals who meet the expectations of communities is a key part of delivering an accessible, acceptable service (Harris, 2014).

A national seminar was convened and experts from around South Africa participated. The purpose of the seminar was to validate the emergent theory in the hope that it will contribute to the discourse surrounding the development of competency in social accountability and its impact in education and practice of medicine in South Africa and abroad.

1.4 Research Aims and Objectives

This study aimed to:

- develop a theoretical framework within which to understand the definition and application of social accountability as an attribute of individuals graduating from a South African medical educational institution;
- evaluate this theoretical framework for its applicability to educational settings at other South African medical schools.

The objectives of this study were to:

- explore and interpret the experiences of communities associated with the Wits medical undergraduate programme in their encounters with medical practitioners and their expectations of socially accountable medical practitioners.

- describe, analyse and interpret the experiences and aspirations regarding social accountability of the partners in education in the Wits teaching complex (academic staff, health service managers and others)responsible for the education of undergraduate medical students.
- explore and analyse the views and experiences of final year Wits medical students regarding social accountability and the impact it has on their future careers.
- develop a theoretical framework within which to describe the nature of social accountability in this institution as emerging from the three preceding parts of the study.
- test this theoretical framework with stakeholders in the education of medical students at other South African medical schools.

1.5 Nature of the Study

A qualitative approach was used to conduct this study. As the nature of social accountability is central to human development and the achievement of health for all people, the study was undertaken in the interpretivist philosophy drawing from a transformative world view (Creswell, 2014; Schwandt, 2000). Charmaz's (2010) approach to grounded theory was applied to the data and guided both the conduct of the study and the analysis of emergent data.

The study was conducted in five parts:

1 The communities

A series of eight focus group discussions were held in communities in which the Wits medical students spent at least two weeks of their learning time. Participants were drawn from two rural (5 focus groups) and one large metropolitan area (3 focus groups). These group discussions were convened from November 2012 to August 2013. The participants discussed their expectations of doctors, the health priorities of their communities and the community's relationship with the university.

2 The medical students

Final year medical students participated in the study in a series of ten focus group discussions. Groups were constituted in two ways: an initial call for volunteers to participate at the end of 2012 immediately before graduation and through the purposive selection of clinical groups of students in 2013 in the three months prior to their final examinations. These discussions explored the students' understanding of social accountability, their reflection on the WHO definition and their experiences of curricular activities which supported the notion of accountability and those which detracted from it.

3 The partners in education

Partners in the education process for doctors included the academics who teach in a formal association with the university curriculum as well as individuals who manage the health care system in which the students conduct their work place based learning opportunities either at provincial or local government level. The participants were interviewed using a semi-structured in depth interview format exploring their understanding of social accountability, principles guiding their teaching and their aspirations with regard to the graduating doctor. The interviews were conducted between June and October 2013.

4. Proposing a theoretical framework.

Themes which emerged from the data collected in the first three parts of the study above were developed into a theoretical framework following the procedures suggested by Charmaz (2010). Charmaz (2010) refers to Glaser and Strauss who have suggested that there are various components in developing a grounded theory, namely the immersion of the researcher in data collection and concurrent data analysis, analytic coding and the constant comparative method allowing for the emergence of theory at each step of the research process (Charmaz, 2010).

Different levels of coding were applied to the data in order to allow the conceptual framework to emerge (Charmaz, 2010). Focused coding was used initially and later evolved into theoretical coding (Charmaz, 2010). The emergent theory was used to create a conceptual framework which was then tested in part five of the study.

5 The experts' reflections

Following the emergence of a theoretical framework for social accountability in the education and practice of medicine using a Wits sample, this framework was interrogated by a national panel of experts in medical education. These experts were drawn from seven of the eight medical schools in South Africa. These experts, who have both clinical and educational expertise, were purposively selected and invited to participate in a national seminar. The purpose of the seminar, convened in March 2014, was to examine the framework which had emerged from the data. The expert panel offered insights into the validity of the proposed theory. The evaluation model proposed by Chinn and Kramer (2008) was merged with ideas from Glaser (Charmaz, 2000) in order to guide the discussion of this panel. The former ask questions related to clarity, simplicity, generalisability, accessibility and the latter address fit, functionality, relevance and adaptability of the emergent theory.

1.6 Ethical considerations

Ethical clearance for the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (certificate number M120965; See Annexure A). The proposal for this research was approved by the Graduate Studies Committee of the university in January 2013 (See Annexure B).

All the participants in the study provided written consent for allowing the recording and verbatim transcription of the focus group discussions and the semi-structured interviews.

1.7 Summary

This chapter introduces the idea of social accountability as it applies to the achievement of global health. It refers to the growing calls to use social accountability to evaluate and accredit medical education institutions. A reflection on the South African health system highlights the challenges experienced currently and the consequent need for a transformative model of education for the professionals who enter that system. The chapter describes the need for this study

and outlines the different stakeholders who have contributed to the emerging theoretical framework.

The next chapter will review the literature regarding social accountability.

Chapter 2:
Literature Review

2.1 Introduction

This chapter reviews the meaning of social accountability, exploring the literature which describes the contexts in which it becomes important in society and in health – both in the delivery of health care and in the education of health professionals.

Social accountability is imperative for the achievement and maintenance of a more equal world (United Nations Development Programme, 2013). The idea of social accountability conjures up the image of a society on the one hand and the relationships within that society through which accountability is processed on the other. Necessarily, social accountability will manifest differently in different societies, but this will always be governed by relationships and often power dynamics between the different actors in that society. This chapter explores the meaning and experience of social accountability in the global discourse on the meaningful development of all communities. It then examines the growing literature on the social accountability of medical schools which has emerged since the WHO declaration by Boelen and Heck (1995) who defined the term social accountability. Their road map for the achievement of health for all through social accountability forms the template of this review as it speaks directly to the complex relationships within health care and health systems globally which has relevance for South Africa. The availability of doctors remains a key determinant for the success of health systems globally. The review concludes with an analysis of the competencies and capabilities which a socially accountable doctor requires as well as a reflection of the professional community into which medical students enter on graduation.

2.2 An unequal world

The majority of African people are poor often as a direct consequence of the legacy of colonial conquest (Barrett et al., 2006). They are part of the global poor who continue to be a significant challenge as we set out in a new millennium. The consensus that global poverty eradication is a priority for the achievement of a range of social development goals is best captured in the Millennium Development Goals (United Nations, 2013). First released by the United Nations in 1990, the goals may be seen as an expression of global solidarity and cooperative action involving leaders from across the globe (United Nations, 2013).. The target of global social development includes the eradication of poverty, the education of people and the improvement of health and global partnerships which form part of the stated goals for achievement by 2015 (United Nations Development Programme, 2000). They remind us of the ongoing entanglement of health and poverty in society. The goals also attempted to create a framework through which measurement can be made and progress can be monitored (Vandermoortele, 2008). Vandermoortele (2008) goes on to suggest that while only a third of the world's countries had amended their national policy towards the achievement of the Millennium Development Goals, the attainment of these goals may be accelerated by altering them for context and the creation of intermediate targets to deepen the political accountability required to achieve them.

2.2.1 Accountability in society

Maru (2010) asserts that a defining aspect of the social accountability movement is that it establishes and responds to the social needs of the communities in which it prevails. Boelen and Woollard (2011) affirm this idea by arguing that in a socially accountable institution, social needs are part of the feedback process for management. In a series of discussions, the World Bank uses the definition of social accountability as being the process through which engaged communities, as civil society, "*participate directly or indirectly in exacting accountability*" (Malena et al., 2004:3). Malena et al. (2004) argue that the importance of social accountability is that it results in improved governance and greater empowerment of communities in the achievement of the developmental goals of eradicating poverty and its consequences in communities (Malena et al., 2004). Poverty and

the income inequality which accompanies this in many societies lead to communities with low levels of education and very low levels of social capital (Kawachi and Kennedy, 1997). As a result of the low social capital, poorer communities are often unable to exact this accountability or access the relevant services provided for the alleviation of their conditions Habib (2013) asserts that the ability to exact accountability is important. The author refers to the concept of *substantive uncertainty* where the political ruling elites are constantly aware of the ability of the citizenry to change the government through democratic processes (Habib, 2013:60).. It is an idea which helps to disperse power through the citizens.

The World Development Report of 2004 offers four reasons why the poor may not be receiving the best of the services being offered: the service especially in health and education is exploited by the rich, the resources available to the lowest level providers is a small portion of the available funding in a system, professionals in these areas do not deliver an adequate service and there is often little demand from the poor themselves (World Bank 2003). The three players in the provision of services to the poorest are the state or policy makers, the service provider and the community itself (See Figure 2.1). The relationship between the players in the achievement of developmental goals of poverty eradication is well described in the World Development Report of 2004 (World Bank, 2003).

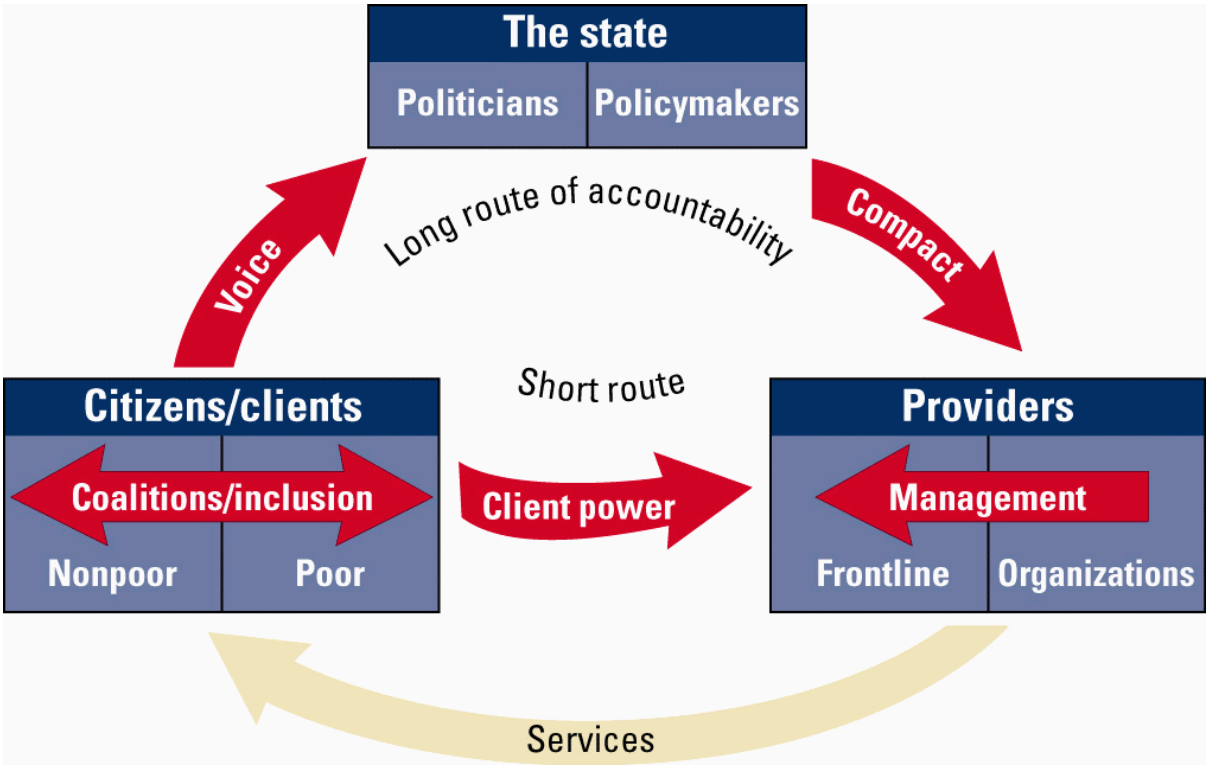


Figure 2.1: World Development Report 2004 Social Accountability framework (reproduced, with permission, from World Development Report (World Bank, 2003)

While the relationship of the community to its policy makers is broadly governed by the electoral processes, these processes are often not immediate and not always effective in hearing the voices of communities. This is evidenced in the growing number of service delivery protests which characterise the South African political landscape (Habib, 2013). The policy maker is responsible for the appointment of appropriate providers (seeking out those with an intrinsic desire to serve the poor) and the monitoring of the service which they provide (obtaining information on the measured delivery of service) (World Bank, 2003). Scott (1982) suggests that there are three models for managing health professionals in an organisation, namely, autonomous (the professional sets the terms of work and accountability), heterenomous (there is a clear subordination of professionals to an administrative framework) and conjoint (coexistence in interdependence and mutual influence). He argues that each of these have advantages and disadvantages, with the conjoint being a more aspirational model (Scott, 1982).

There is little evidence of the achievement of this ideal in the South African health system (Chopra et al., 2009; Mayosi et al., 2012)

The third level of relationship is between the service provider and the client. This relationship represents a shorter route for the exacting of accountability and is one that needs development. It may be in this area that the increased empowerment of communities may have the greatest impact.

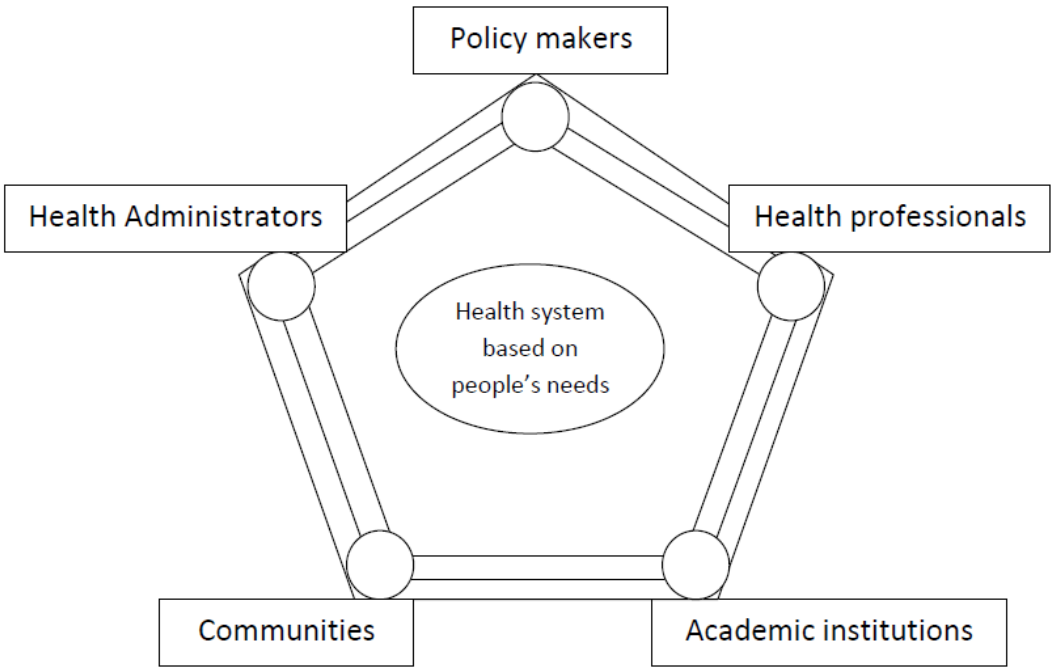


Figure 2.2: The social accountability partnership pentagram (Woollard, 2006)

The partnership pentagram explicates these relationships further by separating the policy makers and administrators, but emphasizing the relationship that all the stakeholders have on the health system (Woollard, 2006) (See Figure 2.2). The system suggested includes the academic institutions as part of the influential players. The pentagram shows graphically that all the partners in the pentagram have an equal role and responsibility for a health system which is responsive and adaptive to the needs of the community. This places communities on an equal footing to other partners in an empowered relationship.

2.2.2 Community Empowerment

The Alma Ata declaration of 1978 alludes to an increased role for communities in their health through the following statement in Clause IV: *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care* (World Health Organisation, 1978). This role of the community is emphasised again in the Ottawa Charter for Health Promotion in 1986: *At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies* (World Health Organisation, 1986). There are many different manifestations of empowerment both at the individual and community levels (De Souza, 2011). Rifkin (2007) developed the CHOICE model for the empowerment of communities in order to facilitate the implementation of public health projects and programmes. The key elements of CHOICE are capacity building, human rights, organizational sustainability, institutional accountability, contribution and enabling environment (Ratna and Rifkin, 2007). The framework emphasises the continuum of actions and processes which lead to the effective empowerment of the communities especially in the achievement of improved health (Ratna and Rifkin, 2007) (See Table 2.1).

Table 2.1: Rifkin's CHOICE framework in tabular form

C	Capacity building	People learning to do for themselves
H	Human rights	Participation in their own life decisions
O	Organisational sustainability	Allows programmes to continue for the long term
I	Institutional Accountability	Building relationships of engagement with providers of services
C	Contribution	The contributions which active participants make
E	Enabling environment	Allowing partnerships between the professionals and lay people

Laverack (2006) reviewed the literature and reports the use of nine empowerment domains which include participation, community based organisation, local leadership, resource mobilization, asking “why”, problem assessment, linkages, role of outside agents and management of the programme (Laverack, 2006; World Health Organisation, 1986). These concepts align well with the framework offered by Rifkin. In addition, Laverack avers that it is the role of the health care professional to empower people in the community to engage with the social determinants of health (Laverack, 2006).

There is a need to educate the health professional, and particularly medical, graduate for the role of empowering communities. The caution which needs to be heeded is that the professional should not act upon the community which is at risk because of the asymmetry of knowledge and power between themselves and the communities but rather collaborate with the said community (Walker et al., 2009). Professionals are often aligned with systems which in the view of Mcknight (1997) may prevent significant empowerment of communities because they view health and services as commodities.

Mcknight (1997) argues that the community is already vested with substantial gifts and capacities which need to be acknowledged and harnessed for their progress. He further argues that systems (such as health services) often relate to communities in a manner which serves the purpose of the system which needs to appear to value community input in processes. He describes these levels of community engagement as being system outreach (community is subsidiary to system), volunteerism (community is co-opted to work for free) and citizen advisory group (a group chosen by the system to respond in a predetermined way) (Mcknight, 1997).

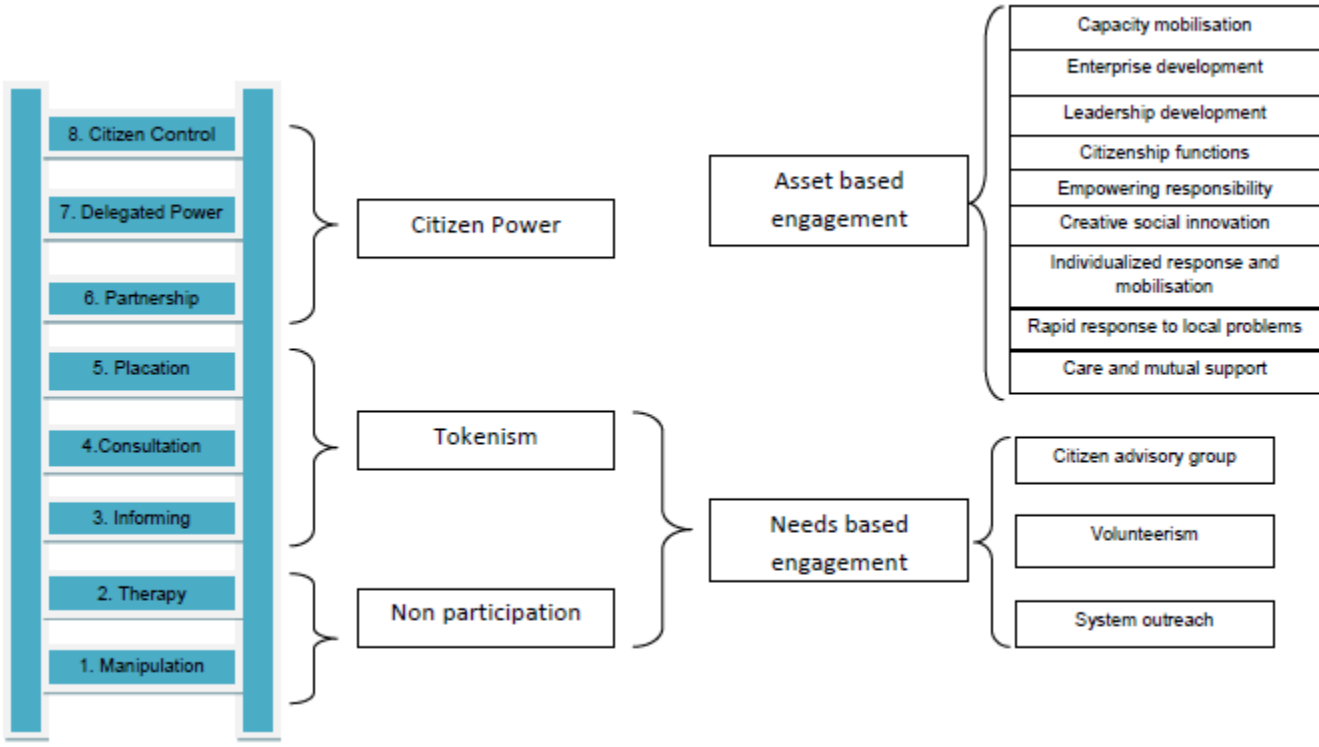


Figure 2.3: The relationship between Arnstein's ladder of citizen participation and McKnight's approach to community engagement (adapted from Arnstein (1969) and Mcknight (1997).

Arnstein (1969) is critical of attempts by those with systematic power who go through the motions of the lower five steps of the ladder (See Figure 2.3), and argues that there is no real empowerment of the community until the partnership stage where real citizen empowerment occurs. Health systems will often decide what the needs of a particular area are and make an intervention. Mcknight (1997) suggests that this is a typical system based approach in which a governing system responds to a perceived need in the community. A system type response often leaves the community involved in the same position as it was before the intervention (Mcknight, 1997; Arnstein, 1969). Laverack (2006) argues that it is important that those who have power – these are often medical practitioners – need to work together with people in communities. He also argues that this power dispersal happens as much because people are looking to participate meaningfully as it happens because of a willingness to share vested power

(Laverack, 2006). This affirms the idea that both parties in the power dynamic have a responsibility in resolving asymmetries of power. The concept of participation demands that the practitioner does not stand back but participates fully with the community in the planning and implementation of possible programmes (Green and Kreutner, 2005).

The domains for examining empowerment in communities are an echo of the asset based approach to community empowerment (Laverack, 2006; McKnight, 1997). The domains listed by Laverack can be seen in the nine features of an asset based community empowerment approach in Figure 2.3. In the PRECEDE phase of the health program planning processes suggested by Green and Kreutner (2005), this asset based mapping process forms an important part of establishing the social capital available for the development of the programme. The greatest challenge is ensuring that the community has the power to decide.

2.2.3 Community Power and Social Determinants of Health

Underserved communities are often on the wrong end of the power differential through asymmetries of wealth, literacy and access (Sandhu et al., 2013). Sandhu et al. (2013) suggest that this asymmetry of power is a direct reflection of the social determinants of health. The WHO Commission on the Social Determinants of Health argue that the asymmetries in access to power and resources lead to a gradient socially which leaves the poor with poorer health both within a country and between nations (CSDH, 2008). The commission goes on to argue that this impacts on unfair access to many of the things which impact a positive daily life (CSDH, 2008). The report recommends the improvement of daily living conditions, tackling the unequal distribution of power, money and resources and the detailed quantifying of the problem and the impact of any interventions (CSDH, 2008). Ashford (2005) argues that the impact of poverty on health is the combination of inadequate information or education, poor quality services with providers who are not responsive as well as cost which limit access. Amongst other strategies of implementation, there needs to be an acknowledgement that these social determinants form the background of the way in which the state works in implementing health policies and in the way in which practitioners are trained to see these as

important (CSDH, 2008). They argue for greater civil society involvement and political empowerment to redirect the socioeconomic forces (CSDH, 2008).

The Marmot Review (2010) highlights the social gradient which exists within countries and the profound effect that this gradient has on the relative health status of communities within a country. The report, compiled for an English context, recommends the adoption of “proportionate universalism” where those communities who are most disadvantaged receive greater attention in the alleviation of health problems. The two policy goals, enunciated in the report, which resonate with the idea of social accountability, are:

> *To create an enabling society that maximizes individual and community potential;*
>
> *To ensure that social justice, health and sustainability are at the heart of all policies (The Marmot Review 2010:14).*

These policy directives respond directly to what Chris Bem articulates as the four challenges to health in the 21st century, namely, burden of lifestyle diseases, environmental change, social inequality and consuming economy. Bem (2010) uses these challenges to support his argument for the introduction of “social governance” as an additional pillar in governance models for health institutions. Social governance would complement the current clinical and financial governance models and would be a *theory, process and ethic that made explicit the social dimensions of health, emphasised an ethic of community, and developed processes of collective responsibility for healthcare provision* (Bem, 2010:475). Bem (2010), acknowledging the social determinants of health, argues that our role as health practitioners includes the empowerment of people towards the creation of responsible, caring communities.

In as much as we regard health as dependent on the structures and relationships in society, social governance implies social accountability in all aspects of relationships in health.

2.3 Social Accountability in Health

In 1995, the WHO introduced a definition for social accountability as part of the discourse towards improving global health equity (Boelen and Heck, 1995). The definition speaks clearly to educational institutions who have:

> *….an obligation to direct their education, research and service activities towards addressing the priority health concerns of the communities, regions and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organisations, health professionals and the public (Boelen and Heck (1995:3).*

The priority health concerns which are referred to in this definition are reflected in the crisis in global health with great inequities between the richer and poorer nations (Frenk et al., 2010). In order to address these inequities, Boelen and Heck (1995) propose a value system for health care systems based on relevance, quality, cost effectiveness and equity. In their social accountability grid, the authors balance these values with the planning, doing and measuring of impact in the domains of research, service and education for medical schools and the health systems in which they are operating (Boelen and Heck, 1995).

Boelen and Woollard (2011) assert that the impact which an institution makes on the health of its communities is a mark of excellence in the tradition of evidence based medicine. In the value system proposed as a part of health care systems by Boelen and Heck (1995) each of these values has a particular representation. Quality refers to good person centred comprehensive care, equity implies equal access to care, relevance demands that the service provided matches the health priorities and effectiveness calls for the best use and distribution of resources (Boelen and Woollard, 2011). There is a growing pressure for medical schools to graduate doctors who have a range of skills beyond technical competence which allows them to respond adequately to the health needs of the twenty first century (Boelen and Woollard, 2011; Woollard and Boelen, 2012; Frank and Danoff, 2007).

2.3.1 Evaluation of institutional social accountability

Internationally, there has been a widening consensus about the meaning and expectations of social accountability (GCSA, 2010). The Global Consensus for Social Accountability of Medical Schools (GCSA), through a multilateral declaration confirmed at a meeting in South Africa, described ten strategic initiatives to develop institutions which are responsive to health needs of their communities and have oriented their service research and educational programmes to this end (GCSA, 2010). These initiatives have a broad scope examining the role of society, urging the relevance of education to the local context and being responsive to the society's health needs. Importantly, the consensus calls for the adaptation of current roles of doctors and other health professionals. It also highlights the importance of outcome based education, improved governance and accreditation processes to ensure the continued improved quality of education. A central theme is the development of sustainable relationships amongst all stakeholders in the health of communities, perhaps most importantly with the partners within a health system (GCSA, 2010).

There is a widening conversation of the multiple facets of relationships which ensure social accountability. These relationships form an important part of the evaluation framework proposed by THENet for the assessment of medical schools (The Training for Health Equity Network, 2011). The framework, dealing exclusively with medical schools, provides a matrix for the evaluation of an institution based on three questions: *how do we work, what do we do and what difference do we make?* (The Training for Health Equity Network, 2011). These questions are an evolution from the idea that for medical schools to become socially accountable they need to actively engage in a clear conceptualization of their intent, clearly define their processes of production and ultimately deliver a graduate who matches the needs of the society (Boelen and Woollard, 2009).

The evaluation framework, in calling for institutions to answer these questions, centralises the interrelationship of the key participants in the project for health for all – the community, the education institution and the health system (The Training for Health Equity Network, 2011). Boelen and Woollard (2011) propose that excellence in medical education must be governed by a sense of social

accountability. Acknowledging that social justice and the pursuit of economic development and progress are often in tension, the authors create a social obligation scale which describes the gradient of addressing social needs moving from responsibility through responsiveness to the achievement of accountability (Boelen, 1994; Boelen and Woollard, 2009; Boelen and Woollard, 2011; Woollard and Boelen, 2012).

The relationships between the community, the educational institution and the health system is a reflection of the dynamic interplay of good governance and community empowerment which facilitate the achievement of developmental objectives discussed earlier (Malena et al., 2004).

For the purposes of this review, the developmental objectives may be construed as the achievement of optimal health for communities. Community empowerment means the increased role of the community in determining the health priorities and concerns which institutions should address in their education programmes. Good governance will be related to the expected professional attributes which form part of the competencies of graduates.

The graduating professional should demonstrate the competency to engage with the health system as well as the people who require care. One of the essential features of an adequate health system is a responsive work force who will treat all patients with fairness (World Health Organization, 2007). In their recent call for the renewal of efforts in the education of the health work force the WHO addresses issues such as adaptive curricula which will contribute to an enhanced quality, quantity and relevance of the graduates which emerge (World Health Organization, 2013)

2.3.2 Responses in medical education

There have been numerous responses to the call for social accountability in medical education. Worley et al. (2006) showed students had positive experiences in a rural placement. These experiences were influenced by clinical, institutional, societal and personal factors. The concept of *symbiotic education* emerged with four mutually beneficial relationships existing with the student central to these (Worley et al., 2006). The four relationships are between personal principles and

professional expectations, clinicians and patients, health service and university research and finally, government and community (Worley et al., 2006). The PRISMS model for medical education which represents Product focused, Relevant, Interprofessional, Shorter and smaller, Multisite and Symbiotic dimensions may be a possible model for guiding curricula to become more socially accountable by making the commitment to symbiosis more explicit (Prideaux et al., 2007).

In response to this challenge the medical education community has embarked on three movements which have begun to increase levels of accountability to the communities in which research, education and service may occur. These are the increased use of community based education, service learning and the growing movement of clinical longitudinal integrated clerkships.

2.3.2.1 Community based education

Ubuntu – the African philosophy of communal responsibility – has been embraced as part of the central mission at the Walter Sisulu University (Kwizera and Iputo, 2011). This faculty, established in 1985, has built an innovative medical curriculum using three key principles, namely, problem based learning , a community based curriculum and the establishment of a community based network of learning sites (Kwizera and Iputo, 2011). This faculty continues to make a significant contribution to health care in South Africa.

2.3.2.1 Service learning

The University of Sasketchewan embarked on a service learning project entitled “Making the Link” with an explicit mandate to get students to “practice altruistic medicine in underserved communities” (Meili et al., 2011). Part of their mission was to teach social accountability through community involvement and the establishment of relationships between the students and selected underserved communities (Meili et al., 2011). Their results showed a greater appreciation by students of the experiences of underserved communities.

2.3.2.2 Longitudinal Integrated Clinical Clerkships

In their recent dialogue on the possibility of change in medical education achieving improvements in society, Hirsh and Worley explore the many journeys which medical education has taken (Hirsh and Worley, 2013). While they assert that there should be a principled guided approach to reform and innovation, they list a series of positive outcomes from the establishment of longitudinal clinical experiences for students. These include improving the participation of students in the care process facilitating their learning through commitment, enhancing their learning through continuity both with patients and teacher, centralising the integration of learning and selecting instructors and venues with educational intent which no doubt assists in addressing the hidden curriculum which has an important impact on learning (Hirsh and Worley, 2013; Hirsh et al., 2007). These studies of integrated longitudinal clerkships have demonstrated the importance of relationships both in the students' learning and the patients' experience of the learning environment.

Despite Flexner being credited with entrenching the dichotomy of the laboratory science education and clinical education, his original report heralded the importance of relationships which are at the heart of longitudinal clerkships (Flexner, 1910). In fact, he characterizes the features of a good clinical education as follows:

> *…to sample a school on its clinical side, one makes in the first place straight for its medical clinic, seeking to learn the number of patients available for teaching, the variety of conditions which they illustrate, and the hospital regulations in so far, at least, as they determine (1) continuity of service on the part of the teachers of medicine, (2) the closeness with which the student may follow the progress of individual patients and (3) the access the student has to the clinical laboratory (Flexner, 1910:93-94).*

Continuity of teaching and learning as well as patient care were seen to be essential. Flexner (1910) offered additional ideas on the interaction of the basic science disciplines and the subsequent clinical learning. Flexner was already

aware of the tension between the basic sciences in their perspectives of biosystems and the clinical practice as the systematic manifestation of these biosystems, but was clear that the didactic presentation of these sciences was inappropriate. He characterised the interface between these two interdependent parts of medical training as follows:

> *….the actual value of these conceptions and of the habits grounded on them (the laboratory sciences) depends less on the extent of his acquisitions than on his sense of their reality. Didactic information, like mere hearsay, leaves this sense pale and ineffective; a first-hand experience, be it ever so fragmentary, renders it vivid (Flexner, 1910:68).*

The above three responses from the medical education community can be seen as dimensions of community engagement or different levels of social responsiveness. They speak to all five dimensions of the proposed taxonomy offered by Barker (2004) – the *public scholarship* of such actions, often through *participatory research* which build *community partnerships*. These partnerships necessarily form important networks enhancing the civic capacity in communities (Barker, 2004).

Much of this vocabulary has already permeated the South African higher education discourse in a quest for the engaged university. Kruss (2012) uses this context to frame a discussion which bases this engagement within the relationships of universities to a series of 'external social partners'. A series of papers in a report commissioned by the Council for Higher Education reflect on the meaning of the relationships between the academy and the broader society which echo the need for greater clarity of the meaning of engagement and the potential for a positive effect within the community where the engagement occurs (South African Council for Higher Education, 2011)

2.4 South African Health System

South Africa has inherited a dysfunctional health system from a long history of discrimination (Coovadia et al., 2009). This legacy has led to significant challenges for the post-apartheid government in addressing the health inequities. The Lancet series on health in South Africa in 2009 reflected on the quadruple burden of

disease which pervades the health system in the country leading in some instances to the reversal of achievements in the quest for the Millennium Development Goals for 2015 (Chopra et al., 2009).

The health status of the nation is perhaps one area in which this misdistribution is most powerfully reflected and experienced. The health status of a population is determined by the relationship between the burden of disease which it carries, as well as the social dimensions which form the background in which a population experiences health or disease. Globally the developing world bears the greatest burden of disease and yet often has inadequate health care systems characterised by unequally distributed health care personnel.

South Africa's burden of disease is visible in maternal and child health, violence and personal trauma, infectious disease and non-communicable diseases (Chopra M et al., 2009; Coovadia et al., 2009). While South Africa reported in 2009 a series of reversals in terms of the Millennium Development Goals there are positive signs that the tide may be turning towards achieving some of these (Chopra M et al., 2009; Chopra et al., 2009).

In an updated report, Mayosi et al. (2012) report a series of developments leading to the improvement of health service delivery addressing the entire quadruple burden of disease which previously warranted concern. There are improvements in HIV control in the perinatal period for both mothers and newborns, non-communicable diseases have become focus of surveillance, improvements have been noted in the monitoring of HIV and TB while violence has begun to be addressed through a renewed focus on available evidence (Mayosi et al., 2012). The report argues that much of the progress achieved since 2009 has been as a result of a renewed leadership at the highest levels in the South African health system. Mayosi et al. (2012) support the notion that effective leadership is needed at all levels of the system in the engagement with government agencies and the people they serve (Mayosi et al., 2012).

2.5 Medical Education in South Africa

Zwi et al. (1994) suggested that 1994 was a good moment in which to reorient medical education and expect that medical schools become more extroverted in

their engagement with communities and their needs. The authors reflected on recommendations from an international medical education meeting which recommended that mission statements should reflect medical schools' commitment to communities, to programmes that match local health problems, to the production of graduates who have the competencies to apply individual and population health principles, interprofessional education and the conversion of data into applications for teaching, research and service (Zwi et al., 1994).

Zwi et al (1994:426) address these issues with several questions which over the last two decades have become central to defining the levels of accountability of medical schools:

> *Is it reasonable to suggest that all medical schools in South Africa adopt the basic recommendations cited above?*
>
> *Would medical schools accept a social responsibility to the communities in which they are located?*
>
> *Even if institutions do not accept such a challenge, could communities demand it of their local schools?*
>
> *Could one assert that each medical school should define a population with which to relate?*

These questions continue to resound in the debates in South African medical schools about their need for responsiveness and accountability to the community. Seggie (2010) reviewed the progress made in South African medical education since these questions were asked. The author concluded that South African medical education has made salutary advances across all of its eight medical schools with increasing attention being paid to excellence and relevance, student centred learning and problem based strategies; moving from a biomedical model of patient care to one which is biopsychosocial; the development of approaches to identify core competencies; the highlighting of multiprofessional learning and increasing community based learning (Seggie, 2010).

The CHEER Peer Review of one South African school for health professionals tested the evaluation instrument for THENet (The Training for Health Equity Network, 2011). The report found that the understanding of social accountability amongst both staff and students was variable. Amongst the findings was the definition of community being twofold: an internal community which comprised students who were often from disadvantaged communities and in need of both material and academic support as well as an external community within which students worked (Michaels et al., 2013).

2.6 The MBBCh degree at Wits

The Faculty of Health Sciences at the University of the Witwatersrand delivers an undergraduate programme for the MBBCh degree which allows graduates entry into the third year of a six year programme and direct entry for students who enter from secondary school. The six year programme is delivered through two years of a traditionally structured basic science curriculum – in the first year the quantitative natural sciences and courses in sociology and psychology are taught. The second year is made up of anatomy, physiology and molecular medicine – the latter being one of the earliest such courses to be offered to medical students in the country. Graduate entrants join the school leavers in the third year of study. In the third year pathology, microbiology, pharmacology are learnt through a hybrid problem based learning curriculum which is structured into body system based blocks. The final two years of the programme are divided amongst the clinical disciplines in rotations of six weeks duration each. Each of these last two years is accompanied by an integrated assessment of learning – in the fifth year of study consisting of material which is not covered in any of the clinical disciplines and in the final year assessing material learnt in any of the preceding four years. A multidisciplinary block, Integrated Primary Care, was introduced into the final year of study (Year 6) which was taught at district hospitals associated with the university in both urban and rural settings. Students attend an elective period of two weeks at the end of the third year and another of four weeks at the end of the fifth year. The university declared that graduates from the new medical curriculum in 2003 should have the competencies to provide comprehensive patient care in a plurality of health and social contexts, to deliver appropriate care beyond the immediate consultation and

short-term management plan, to function with sufficient professionalism and cultural and social sensitivity and be able to deliver care to geographically defined communities. To support these renewed commitments, the curriculum is characterised by four themes in an attempt to spiral learning in all areas through the years of the curriculum. These four themes are: basic clinical science (the spiraling intention for basic science to be learnt alongside clinical science), community – doctor (with an emphasis on understanding the patient as member of a broader community), patient – doctor (centralisng this relationship as a cornerstone to effective health care) and personal and professional development (a theme which includes self awareness and reflection and bioethics).

2.7 Health professionals for the 21st century

It is imperative that the health professional in the twenty first century needs to be a leader in the system who is an effective change agent for the improvement of the health status of the world's people (Frenk et al., 2010). The Lancet Commission of 2010 speaks of the need to transform the education of health professionals to enable graduates to be more responsive to the social needs of communities (Frenk et al., 2010; Boelen and Woollard, 2011). The authors argue that graduates need new competencies which allow them to engage the uncertainties of the systems and practice in health in the twenty first century (Frenk et al., 2010). It is this adaptability of the professional which is gaining traction in how the meaning of health is conceptualized (Huber et al., 2011).

2.7.1 From pathogenesis to salutogenesis

Henry Pritchett, President of the Carnegie Foundation, in his introduction to the seminal Flexner report highlights the five areas in which the report has impact as being a reduction of the number of doctors trained in favour of improved quality, the elimination of commercial schools, the acknowledgement of the increasing costs of training in particular the affordability of laboratory facilities and the need for hospitals which were under educational control (Flexner, 1910). The fifth area of impact is the point to counter the argument regarding the reduction of opportunity for poor students to train as doctors (Flexner, 1910). The latter is what has been referred to as the changing nature of admission to the medical schools

of this era (Markowitz and Rosner, 1973). Indeed, Pritchett affirms the improvement of quality in medical schools which the Flexner report heralds, but one cannot miss the emphasis on the need to reduce the numbers of doctors in order to assure satisfactory incomes for practitioners (Markowitz and Rosner, 1973; Flexner, 1910).

Flexner may be credited with setting medical education on a renewed trajectory in which the changing of the apprenticeship model of education was replaced with a split model to include specific time for the basic sciences followed by a second phase for the clinical sciences (Flexner, 1910). While this is the most commonly attributed contribution made by the report, seldom are the broader aspects of being a doctor emanating from the report noted: … *the physician's function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well being* (Flexner (1910:26).

Flexner's call here is that physicians need to be social and preventive practitioners who contribute positively to physical and moral well being in the manner becoming a well rounded education. This perspective is often lost in the debates which surround the report and yet may be an early sign of the salutogenesis which needs to characterise health in the 21st century and the education of health professionals for new and evolving expectations which the new millennium brings (Flexner, 1910; Frenk et al., 2010; Pauli et al., 2000c).

Pauli et al. (2000a) posit that Flexner (1910) shifted the focus to where medical education occurred leading to the universities, hospitals and clinics becoming the places where students had their formational learning experiences (Flexner, 1910; Pauli et al., 2000a). The authors go on to describe how through the evolution of medical diagnostic thought, medicine has come to a nosology which may be defined as a linear causality model (Pauli et al., 2000a). They assert that this biomechanical view of disease has been responsible for much of the progress that medicine has seen in the past two centuries. They argue the need for a shift in the thinking which governs diagnostic process because in a world of complexity what one perceives is codetermined by the one who perceives. The perceptual world is

made up of multiple systems and self organization explains the development of many biosystems (Pauli et al., 2000a).

2.7.2 New professional paradigms

Reconstructing professionalism and its paradigms means that universities begin to define what they mean by transformation. While the discussion of transformation in higher education in South Africa has been characterised by a demographic transition, there is a growing need to engage with transformation with the intention of transforming graduating professionals capable of responding to the country's reconstruction and developmental priorities (Walker et al., 2009). Walker et al. (2009) propose that the university makes a contribution towards poverty reduction at two levels - by transforming the competencies of students in professional education and through the empowerment of disadvantaged individuals and communities (Walker et al., 2009). The authors go on to suggest that universities should encourage students in the professions to apply the knowledge learnt through a praxis pedagogy which comprises three elements. The three elements (Walker et al., 2009) of this pedagogy are:

- Contextual knowledge and critical reflective understanding of their world of work
- Developing identity, commitment and community allowing the practice of change agency
- Transformation in South African society is reflected through transformative learning strategies which challenge students through participative pedagogy

Freire (1996) characterises the transformative nature of education as being the difference between naïve thinkers who accommodate the normalized reality of today and critical thinkers who continually acknowledge the transformation of reality in pursuit of greater humanization of people (Freire, 1996).

Linked to this greater humanization, the Charter on Medical Professionalism carries forward this idea of professionals being responsible for the greater good (Medical Professionalism Project, 2002). The charter centralises three fundamental principles: patient autonomy, patient welfare and social justice. The

latter two speak directly to the dual role of the medical professional as that of advocate for the individual patient as well as for the just distribution of those social resources which may determine the adequate care of the patient (Medical Professionalism Project, 2002).

This charter represents a new direction in defining medical professionalism within the realm of social justice. Markowitz and Rosner (1973) argued much earlier that the transformations seen in medical education during a period in which the Flexner report was released served to consolidate an elitist position for the profession (Markowitz and Rosner, 1973). The movement was seen as part of the corporatization of America when there was a consolidation of the economy in the interests of blocks of expertise. The extension to medicine then implied that only people of a particular social class became eligible to study medicine – the result being the exclusion, amongst others, of blacks and women – whose colleges of medicine had begun to fold even before the Flexner Report supported this (Markowitz and Rosner, 1973).

The reaffirmation of social justice in the physician's charter on professionalism is an important emphasis. Collier (2012) argues that society has always expected much of those who are part of the healing communities. The lay society has given many privileges to the professions, but in return has an expectation that its members will behave in an altruistic manner (Collier, 2012). This traditional view of the contractual relationship between the profession and the public has been eroded especially in the United States of America with the increase in health care costs and the apparent decline in doctors' concern for their patients (Collier, 2012). Creuss and Creuss (2008) explore the nature of the social contract between the society and the medical profession and show that the contract now has more participants and that there are a growing number of influences on this contract which may influence it but not be party to it. They argue that the social contract idea enhances the understanding of medical professionalism through a clear statement of the "collective expectations" of all the parties – patients, public, government – as well as the professional obligations of the profession (Creuss and Creuss, 2008). This contractual engagement may facilitate the responsibility of the professional community to address the needs of communities directly.

There are no data from the South African context which address the conceptualization of social accountability. Internationally, there is no description of how the various stakeholders in health such as communities, medical students and those who partner to educate professionals perceive social accountability and how it impacts on each of their situations. This study will seek to address this gap in the literature.

2.8 Summary

This chapter has described the nature of social accountability in society at large and its potential impact for health. There is a renewed emphasis on the shift of health care from disease to wellness. The Lancet Commission's report calling for a different kind of leadership in health professional graduates speaks to a renewed idea of what professionalism demands of doctors in the twenty first century. There is also a reflection on the multiple relationships which govern the delivery of health care to people in greatest need. These relationships suggest that the graduate for the twenty first century should have the capacity to understand the complex adaptive systems which pervade health care which is often developed through deliberate practice and the nurturing of sound relationships.

The next chapter will describe the methodology employed for this study.

Chapter 3:
Methodology

3 Methodology

3.1 Introduction

This chapter describes the methodological approach taken in the conduct of this study. It begins by listing the aims and objectives of the study and then provides an overview of the study. The overview of the study discusses the context of the study. The research procedures which have been applied are discussed in general terms as they apply to all parts of the study and the details are then discussed in the subsequent chapters dealing with each part of the study. The study was conducted in five parts.

3.2 Research Aims and Objectives

This study aimed to:

- develop a theoretical framework within which to understand the definition and application of social accountability as an attribute of individuals graduating from a South African medical educational institution;
- evaluate this theoretical framework for its applicability to educational settings at other South African medical schools.

The objectives of this study were to:

- explore and interpret the experiences of communities associated with the Wits medical undergraduate programme in their encounters with medical practitioners and their expectations of socially accountable medical practitioners.
- describe, analyse and interpret the experiences and aspirations regarding social accountability of the partners in education in the Wits teaching complex

(academic staff, health service managers and others) responsible for the education of undergraduate medical students.

- explore and analyse the views and experiences of final year Wits medical students regarding social accountability and the impact it has on their future careers.
- develop a theoretical framework within which to describe the nature of social accountability in this institution as emerging from the three preceding parts of the study.
- test this theoretical framework with stakeholders in the education of medical students at other South African medical schools.

3.3 Overview of Research Design

This contextual study was conducted between November 2012 and April 2014. A qualitative approach was employed using an interpretivist framework to achieve the objectives listed above. This study set out to make sense of the concepts relating to social accountability using grounded theory to understand what these concepts mean to the various stakeholders in the education of doctors (Stern, 2007). Grounded theory was selected for the possibility it offered for the construction of theory using a systematic approach in a constantly iterative comparative approach (Bryant and Charmaz, 2007).

3.3.1 Context of the study

This study was set in the context of the undergraduate medical curriculum of the University of the Witwatersrand, Johannesburg, South Africa. The curriculum is delivered through a six year programme for students who enter directly from school. It allows for the entry of graduates from a range of other degree programmes into the third year of study. Both groups of entrants then complete the MBBCh degree in a combined programme for the last four years of study. The teaching and learning platform for the curriculum comprises the central health sciences campus in Parktown (Johannesburg), the central and district teaching hospitals, community health centres and a series of community sites in the metropolitan areas of Johannesburg, Ekhuruleni and Mogale in the Gauteng

province as well as more remote venues in the Gauteng, Mpumalanga and the North West provinces of South Africa. The curriculum is coordinated by the Centre for Health Sciences Education in the Faculty of Health Sciences but the teaching is offered by full time university academics as well as laboratory based clinical academics who hold joint appointments with the National Health Laboratory Services and by hospital based clinical academics who hold joint appointments either with the provincial or local government health authorities and the university.

3.3.2 A study in five parts

This study was conducted in five parts addressing the expressions of various stakeholders in education of doctors. The first three parts address the meaning of social accountability for three groups of stakeholders in the education of doctors. The remaining two parts construct a unifying framework emergent from these initial encounters and describe a process for validating the theory with a group of national experts. The definition of stakeholders in this study is the groups of people who are part of the education process for medical doctors. They include the communities in which the students may experience part of their learning. The partners in the educational process include the academics, both from the clinical and the laboratory disciplines, who were involved in the teaching of medical students as well as the administrative partners in the government structures responsible for the learning sites where students may have been allocated. The final year students represented a group of stakeholders who may have seen the educational process as being focused on their well being and their achievement of the degree. The first three parts of the study were conducted in the context of Wits University while the remaining two parts attempt to validate the findings of the study in a national context. In summary, the five parts of the study addressed the following:

- The Communities
- The Medical students
- The Partners in education
- Proposing a unifying framework
- The Experts' reflections

The research process in each of these parts will be discussed later in this chapter following considerations which apply commonly to all five parts.

3.3.3 A grounded theory paradigm

The study of social accountability has been based in the evaluative processes for institutions (GCSA, 2010; The Training for Health Equity Network, 2011). The impact of the institutions on the society in which they conduct their education, research and service delivery have formed the focus of approaches to social accountability (Boelen and Woollard, 2009; Boelen and Woollard, 2011; Dharamsi et al., 2011; Woollard and Boelen, 2012; Woollard, 2006).

There has been little study of the response of the various individual stakeholders in the education project of health professionals in general and doctors in particular to social accountability. This study sets out to position the reflections of three groups of stakeholders as emergent theories which may advance the discourse on social accountability.

Belenky and Stanton (2000) suggest that in the development of transformative learning one must acknowledge the asymmetrical relationships within which this occurs. There are asymmetries in the relationship between community members and the doctors they encounter, between the medical students and the clinical teachers they encounter and the university and the community into which they insert. How these asymmetries are manifested can only be explored through critical reflection on the expressions of the various role players in these relationships.

These expressions are given meaning through a grounded theory approach (Charmaz, 2010). Charmaz (2000) proposes that the constructivist approach to grounded theory allows the meaning given by the participants to be explored beyond their literal expression. The phased approach of the interviewing process applied in this study allowed the emergence of framing codes and categories which were continuously interrogated throughout the study. Grounded theory allowed the grounding of an emergent theoretical framework in the interpretation of the data (Charmaz, 2000).

I chose grounded theory because, as described above, it allows the generation of concepts from the participants through their engagement with the researcher as well as with each other in the focus group discussion process. I came to this research informed by the evaluative research described in Chapter 2 but wanting to explore the perspective of groups within the South African context who may not have had the opportunity for reflection on social accountability prior to this study. I set out to explore social accountability, less as a phenomenon worthy of study, but rather as an exploration of the perceptions of the participants which did not have limits or clear definition.

3.3.3.1 Sampling

Grounded theory is characterised by theoretical sampling (Charmaz, 2000). Charmaz (2000) states that theoretical sampling emerges from the initial analysis of the data which has been collected and is applied in an attempt to complete the emerging theoretical picture. The sampling technique differs from random sampling in that it is intended to deepen the construction of theory (Creswell, 2014). This method of sampling relies on the constant comparative process of collecting data, analyzing the data and reflecting on questions emerging from initial concepts and where to obtain the answers for these new questions (Charmaz, 2010; Corbin and Strauss, 2008).

Theoretical sampling was employed in this study until data saturation was achieved in all the stakeholder categories. Corbin and Strauss (2008) use an expanded definition of saturation which goes beyond “no new ideas” to include the cleared definition of the categories which serve the emerging theory.

Details of the sampling process will be discussed further in the sections which follow in this chapter.

3.3.3.2 Research procedures

Two techniques for data collection were used in this study:

- Focus group discussions
- Semi-structured in depth interviews

3.3.3.2.1 Focus Group Discussions

Focus groups were first used in a marketing research context as a method for eliciting information from participants relying in part on the interaction between participants to enrich the data collection (Kitzinger, 1995; Dicicco-Bloom and Crabtree, 2006). Kitzinger (1995) notes three advantages of group discussions for research, namely, they allow participation of people who are illiterate, offer an opportunity for those who prefer group discussions to individual interviews and invites comments from those who feel they have nothing to contribute. Focus groups have become an important vehicle in the participatory action research process which is often an empowering research approach and it is this latter quality which is important in this study (Kitzinger, 1995). The empowering dimension of a focus group may be represented in part by the shift of emphasis from the agenda of the researcher as occurs in a structured interview to the expression of the participants allowing their social realities to emerge (Madriz, 2000). In her discourse on the role of focus groups in feminist research, an essentially transformative lens for viewing society, Madriz (2000) notes the enhanced expression of women of colour through the medium of focus group discussions.

In this study, focus group discussions were used in the collection of data from communities and from students. The community members are disadvantaged in asymmetrical relationships of power through socioeconomic disadvantage (CSDH, 2008) while students may be at the lower end of professional hierarchies which, through the hidden curriculum, may negatively influence their ability to speak freely (Hirsh and Worley, 2013).

3.3.3.2.2 Semi structured in depth interviews

This method of data collection was used in the engagement of partners in the medical education process. These participants may be regarded as peers to the researcher and so not be subjected to the disadvantages of being able to express themselves adequately (Kitzinger, 1995).

Semi-structured interviews are a one-on-one interaction between the researcher and the participant allowing for more narrative based responses (Dicicco-Bloom

and Crabtree, 2006). Dicicco-Bloom and Crabtree (2006) suggest three important phases in the conduct of an interview which maximize the exchange. These are the exploration phase (getting connected), co-operative phase (becoming familiar) and the participatory phase (deepening encounter). While the researcher has his or her own agenda, s/he must be mindful of allowing the world view of the interviewee to be expressed during the interview (Britten, 1995). Britten (1995) notes the importance of flexibility and reflexivity in the conduct of such interviews and heralds the concern of Madriz (2000) of the impact that social distinction of race, class and gender may have on such interactions.

3.3.3.3 Data Management

The interviews and the focus group discussions were recorded and transcribed verbatim. The researcher compiled reflective recordings and notes following the sessions with participants.

Audio recordings were stored on a computer and backups retained on mobile storage devices. The transcriptions were filed with each stakeholder group separate from each other. These were kept in the researcher's office which had restricted access.

3.3.3.4 Data Analysis

Following, and during the discussions with these three role players, the data collected were coded and prepared for analysis. Charmaz (2010) refers to Glaser and Strauss who have suggested that there are various components in developing grounded theory, namely the immersion of the researcher in data collection and concurrent data analysis, analytic coding and the constant comparative method allowing for the emergence of theory at each step of the research process (Charmaz, 2010).

I believe that social accountability is one facet of multi dimensional professional behavior. As I embarked on this project, my belief was, and still is, that social accountability cannot be limited to the study of an institution, but rather it is the interplay between the training institution, the systems of health and the reflective professional self. This may colour the analysis of the data collected, but this was

limited by the constant comparison of the data expressed from the three different groups of stakeholders. Juliet Corbin speaks of her own movement from being a nursing authority to becoming a co-creator of care with her patients (Corbin and Strauss, 2008).

This position is governed by a transformative worldview of research (Creswell, 2014). Mertens (2007) states that the basic beliefs in this transformative paradigm are reflected in social justice which calls for the inclusion of those traditionally marginalized, an interactive link between the researcher and participant both in ideas and process of research as well as ultimately respect for the participants in the research. Mertens (2010:473) aptly describes the transformative paradigm as the *umbrella for research theories and approaches that place priority on social justice and human rights*. It is to this framework of viewing the world that I subscribe.

Thematic analysis was applied to all parts of the study (data corpus) which allowed the reality to be reflected and the reality to be probed (Braun and Clarke, 2006).

Creswell (2003) combines the ideas of numerous authors in his directions for managing the data during a qualitative study. This study applied the six steps which he suggested in the following method:

- organization of the data – focus group interviews were recorded and transcribed as soon as possible after they were conducted
- development of a general sense of the data – this study was conducted in different settings. The general sense was obtained from a collection of discussions at a time. For example, the interviews in the second rural location were informed by emerging ideas from the first. In the Mpumalanga interviews, this meant the conduct of two interviews on one day and these were reflected on together.
- a coding process, descriptions of the various contexts of data collection, development of processes for representing the data and then finally to an interpretation of the data collected. These four steps are described later in this

chapter and facilitated the concepts and frameworks which have emerged (Creswell, 2003).

There are many different views on the achievement of credibility in qualitative research. High levels of sensitivity are observed in the data collection process as well as the analysis of the data through the ongoing reflection on the process and "immersion" in the data (Corbin and Strauss, 2008).

Harry et al. (2005) have offered a data analysis map which is adapted in the following table and best summarises the approach to data analysis:

Table 3.1: A representation of the phases of data analysis in grounded theory

Level 6	Theory	Both substantive and formal theory may emerge at this level
Level 5	Interrelating the explanations	
Level 4	Testing the themes	Referring to key participants for confirmation
Level 3	Themes	
Level 2	Categories	Categories and codes are reviewed for clarity and reliability
Level 1	Open codes	Using focused coding to analyse the raw data

3.3.3.4.1 Trustworthiness

In order to enhance the rigour of the study, member checking was done once the data were analysed. Member checking was done through the evaluation of the data extracted by the internal supervisor as the co researcher in this instance (Creswell, 2003). Throughout the data collection process field notes and memos were made to facilitate the emergence of theory (Charmaz, 2010).

The use of data from three different stakeholders in the medical education project allowed triangulation of the findings. The community, the partners in education and the medical students offered a view on the meaning and relevance of social accountability.

Silverman (2005) argues that the two domains of validity and reliability apply equally to the qualitative research domain as to the quantitative domain. He avers that validity implies truth and that the researcher must guard against "anecdotalism". To ensure validity, Silverman (2005) offers the following processes to assist in enhancing the trustworthiness of the findings of a study:

- refutability principle – addresses the problem of anecdotalism by seeking contradictory explanations for those initially derived. In this study, categories which emerged were supported by expressions from a number of participants.
- constant comparison method – the idea is to check emergent ideas against different situations. The initial community conversations in this study modified the approach to the use of the guiding question in subsequent focus group discussions. The modification of the invitations to the 2012 and 2013 students to participate in this study arose following the emergence of concepts which were strongly influenced by the nature of students who volunteered to participate in the 2012 group.
- comprehensive data treatment – this is the use of all the data collected from all the cases under study. In this study, all data have been analysed and have contributed to the emergent concepts and frameworks.

3.3.4 Ethical considerations

Ethical clearance was obtained from the University of the Witwatersrand Human Research Ethic Committee (Clearance certificate number M120965; See Annexure A). All participants signed a consent form which was informed by translated information sessions prior to the focus group interviews in the case of the groups held with community members and those with the students (See Annexure D, E and G). I explained to participants that I would ensure that they would not be identified as a result of their participation in the study. The protection of confidentiality is difficult in focus groups as it is not possible to protect participants from indiscreet conversations amongst the group of participants and beyond.

Focus group discussions with the communities were held in neutral venues not associated with clinical care. Neutrality is based on the idea that the venues at

which the focus group discussions were held could not be associated with points of care. At Lehurutse, the District Training Centre is a university associated facility which is on the grounds of the hospital but well removed from the areas used for the delivery of care. In the case of the focus groups in the Mpumalanga province, the two community sites used were selected entirely at the convenience of the participants and the final group of younger people (Rural 5) was held at the research facility had no connection with the areas of care in the adjacent hospital.

The audio recordings were stored on a computer which is password protected and has limited access. The transcribers were apprised of the importance of confidentiality. The transcriptions were stored securely in keeping with the requirements of the ethics committee.

The consent process was completed with the help of the research assistant who had been identified to assist with the study in the respective community areas. The research assistant was able to translate the documents through a verbal explanation. The focus group discussions were conducted in the local vernacular language. Contemporaneous translations were done during the discussions. This may have limited the depth of the conversations to some extent. I have some ability in speaking vernacular languages which allowed my credibitity to be enhanced within the focus groups discussions.

In both instances, the participants enjoyed easy access to the venues with no possibility of being identified by any of the role players in the delivery of their health care. No risk has accrued to these participants.

The partners identified for semi-structured interviews were given an information sheet and asked to give informed consent to participate in the study (See Annexures F and G). They also provided written consent for the recording of their interviews (See Annexure G).

Special consent was obtained for the evaluation process. A national seminar was convened with medical education experts from universities across South Africa for the evaluation of the emergent theoretical frameworks. Each of these experts granted consent for the recording of the discussions and the possibility of using

direct and identifiable quotations from the conversations. (See Annexures H and I).

3.3.5 An outline of the parts of the study

3.3.5.1 The Communities

There is no clear definition of a reference community in relation to the University of the Witwatersrand's clinical training platform. Anecdotally, the university has been reluctant to define such a reference community arguing that it serves many different communities through the many sites in which the clinical platform occurs. I chose to define community in this study as people who live in the area surrounding a clinical teaching site in which students spend at least two weeks of their curriculum time. In selecting people to participate in the community focus group discussions two features were emphasised: that the participants were not patients in need of acute care at the time of the interviews and that they need not have been actively engaged in activities around health advocacy either individually or in groups.

The focus group discussions were conducted by the researcher and facilitated by the following questions (See Annexure C):

- Tell me about your experiences of and with doctors
- What do you expect as a member of the community of your doctors?
- What, if anything, do you know about the social accountability of doctors?
- Do you think that doctors should be accountable to communities? If so, how do you think this should happen?
- What do you think are the major health issues in your community?
- Do you think the doctors need to get involved in issues in the community?

While these represent facilitation questions, the researcher probed for clarity and depth of meaning in many of the conversations. Due to the disparate nature of the sites where the university is active, data collection continued until saturation was achieved.

The focus group interviews were conducted in two rural areas (Lehurutse and Bushbuckridge) and at three urban sites in the Johannesburg metropolitan area (Boipatong, Alexandra and Westbury).

3.3.5.1.1 Rural Communities

For the purpose of this study, remote communities are those associated with teaching venues for the university which are more than 200km or two hour's drive from the health sciences campus in Johannesburg, Gauteng (See Figure 3.1).

3.3.5.1.1.1North West Province

At Lehurutse Hospital, the university has established a rural District Learning Centre together with the provincial authorities where students from different degree programmes may be housed for their rural attachments. Lehurutse is approximately 270 kilometres from Johannesburg and is a three hour drive from the university campus in Johannesburg (See Figure 3.1). Medical students are sent to the site as part of their rotations for the Integrated Primary Care (IPC) clerkship for a minimum of six weeks. Students are permitted to self select Lehurutse for their Integrated Primary Care clerkship, so that only part of the final year class would complete their block at this site. Students are accommodated on site in the Learning Centre during this clerkship.

A youth worker from the area was approached to assist with the research process. The young man was willing to assist and due to his participation at a local youth centre was aware of the general community and well accepted by them. He was briefed about the research aims and objectives. The research assistant set up two focus group discussions – one group being with younger people (six participants) and the other with older people (18 participants). Both of these focus group discussions were conducted in the Lehurutse District Learning Centre – a building which is in the grounds of the hospital, but distinct from the hospital structure. The focus groups were conducted on two consecutive days in November 2012 to enable a period of reflection by the researcher on the initial discussion. The participants were known to the assistant but their demographic did not appear to be influenced by personal relationships with him.

3.3.5.1.1.2 Mpumalanga

The university has a strong research and community engagement presence in the Bushbuckridge area of the Mpumalanga province in the north east of South Africa. Bushbuckridge is about 450 kilometres from Johannesburg - a five hour drive (See Figure 3.1). This presence has been developed through the research of the School of Public Health entities such as the Agincourt project. Medical students may be allocated to this area during two periods of clerkship. Initially in the fifth year of study, all students rotate through a public health clerkship for a two week period. The purpose of this clerkship is to orientate students to rural communities through engagement with families as well as the sociocultural practices of people in this area. In their final year, students may select the local hospital in the area as a possible site for the completion of their six week long Integrated Primary Care clerkship. During both these visits to the region students are accommodated in the Wits Rural Facility – a multipurpose, multidisciplinary academic site for the university with residential accommodation.

The research assistant selected for this site was the coordinator of the students' clinical activities in the area. She is responsible for liaising with the university teaching departments and the students who may be on the ground at the local facility during their respective clerkships. The research assistant was briefed about the aims and objectives of the research and was requested to include community members who met the description in 3.3.5.1 above. While many of the participants were known to the assistant, I was reassured during the conduct of the discussions that there was no particular bias in their selection. Three focus groups were arranged and conducted over two days in February 2013.Two focus groups were conducted on the first day, the first of which was made up of traditional healers active in that community (8 participants) and the second comprised members of the community (9 participants), some of whom reported chronic diseases managed by the local hospital facility. A third focus group was conducted with younger people the following day (8 participants).

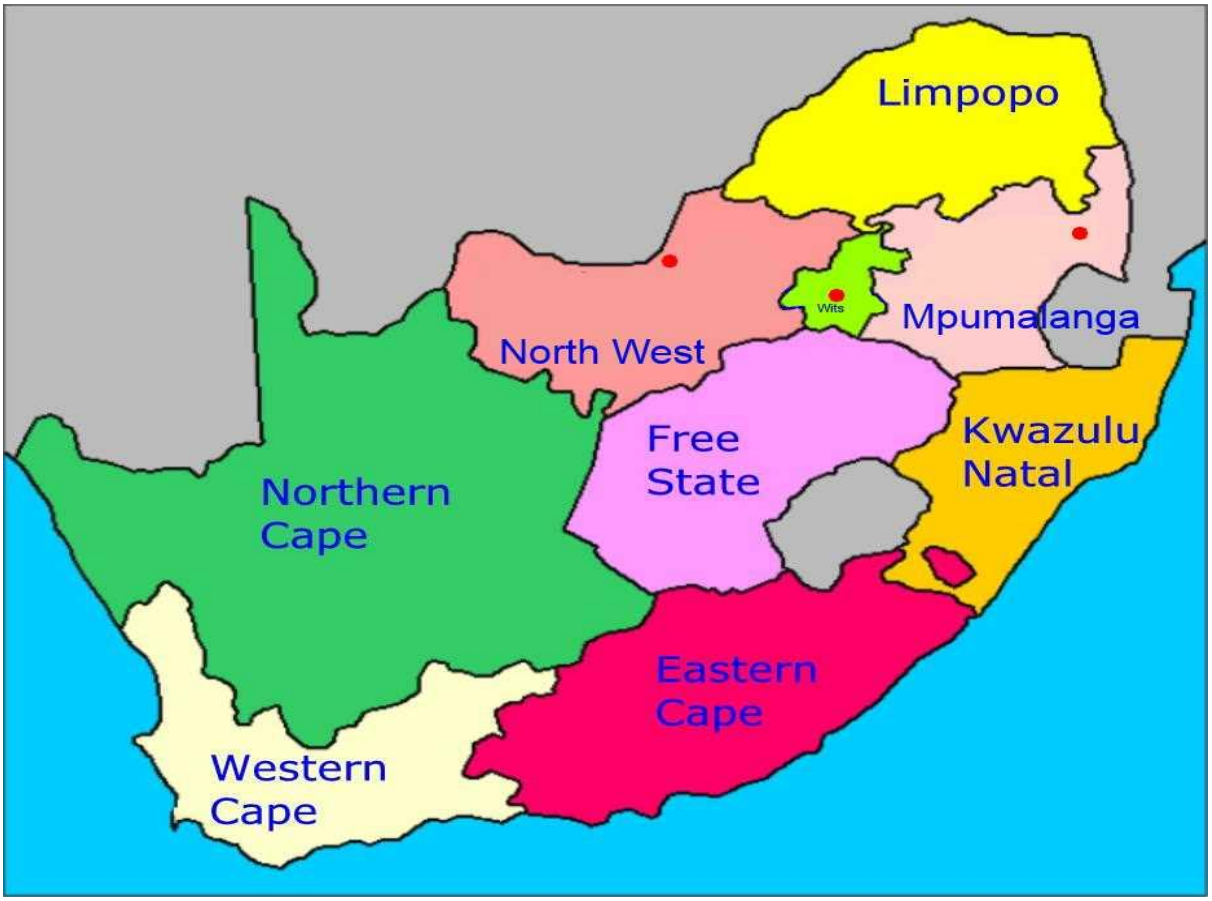


Figure 3.1: Provincial Map of South Africa. Red dots indicate provinces in which community focus group discussions occurred. The light green central province is Gauteng in which the Johannesburg campus is located.

3.3.5.1.2 Urban Communities

3.3.5.1.2.1 Boipatong

Boipatong is a township area in the Vaal Triangle about 75 kilometres south of the Wits University campus in Parktown, Johannesburg. It is associated with the Wits curriculum because it falls within the referral system for the Kopanong Hospital complex at which students may be allocated for the Integrated Primary Care clerkship. The area is a combination of formal and informal housing settlements. The community selected for the focus group discussion surrounded a Primary Health Care outpost associated with the hospital. The arrangement was facilitated by a doctor who manages primary health care in the area for the local authority. The registered nurse in charge of, and the community health workers associated with, the outpost assisted in identifying people from the community to participate in the focus group discussion. The discussion was held with twenty participants in July 2013, in a newly constructed building which will house the health outpost once fully completed.

3.3.5.1.2.2 Alexandra

Alexandra, about 15 kilometres north of Wits University, is a well established Johannesburg township established in 1912. The community is housed in many formal structures amongst which many informal structures house a much larger number of the population. The university has a long association with the Alexandra community especially through the Alexandra Community Clinic. This clinic was a site for much of the university's health activism during the 1980s through a number of its staff. The clinic is now an urban site for the IPC clerkship. The research assistant identified for this part of the study was a young man who had been working for a nongovernmental organisation (NGO) associated with a TB prevention programme in the area. The research assistant was briefed regarding the aims and objectives of the study. The focus group was conducted in a local primary school to assist with the separation from a formal health facility. There were seven participants in this focus group.

3.3.5.1.2.3Westbury

This community is an urban community situated in the surrounding area of the Rahima Moosa Mother and Child Hospital just west of the Johannesburg inner city. Historically this community emerged from the Western Native Township following the removal of people classified as Black in the apartheid era to create a "coloured" community. The community is located between this hospital and the Helen Joseph Hospital which serves more general clinical disciplines. The community is a middle to lower income area with some members able to access the private health care system through medical insurance.

The researcher is familiar with the community and was able to identify a community member to assist with selecting a focus group. Eleven community members participated in the group which met in August 2013 in one of the participants' homes.

3.3.5.2 The Medical students

The study sought to understand what final year medical students perceived social accountability to be, their opportunities to learn to be socially accountable and its possible impact on their choice of work place.

The final year class of 2012 consisted of 193 students (81 males and 112 females). The students were informed of the study through a notice on their electronic notice board in the final weeks of their academic year. Twenty five students responded to this invitation and then participated in four focus group discussions. These data were analysed in an initial phase and the concepts which emerged stimulated further inquiry in additional focus group discussions. It became clear from this initial group of volunteer participants that they had similar views of social accountability which matched the widely held international views from the literature (The Training for Health Equity Network, 2011; Boelen and Woollard, 2009; Woollard and Boelen, 2012; Woollard, 2006). There were also strong views that there were students in the class who held different and sometimes opposing views of the concept of social accountability. A second concept which emerged was that many of the views held by these students were

influenced by the Integrated Primary Care block which students attended in their final year.

As a result of this, a more purposeful sampling process was adopted for the class of 2013 which had 186 students (59 males and 127 females). The final year class is randomly allocated to clinical groups at the beginning of each academic year by the administrative offices. These groups are constructed with the intention of ensuring demographic diversity to encourage students to work in teams that are not self selected. The researcher selected clinical groups which had already been through their Integrated Primary Care clerkship to participate in the focus group discussion. An individual from that group was then requested to inform the group of their invitation to participate. The researcher made arrangements to meet with these selected groups at times convenient for them and at different venues depending on where they were allocated at the time. Seven focus groups were conducted between September and November 2013.

These conversations (2012 and 2013) were guided by the following questions:

- What do you understand by social accountability in medical practice?
- Have you seen elements of this included in your studies over the years?
- How has this affected your views of your own future practice?

Responses to each of these questions were probed for depth of meaning. Focus group discussions continued until data saturation was achieved.

Data obtained continually informed the development and refinement of questions for subsequent groups and theoretical sampling assisted in clarifying concepts which had emerged (Corbin and Strauss, 2008).

3.3.5.3 The Partners in Education

The partners in the education programme for medical students in South Africa are the universities and the governmental structures which provide the clinical learning platforms where students perform the work place based learning. These clinical platforms are governed by two of the partners (policy makers and administrators) in the partnership pentagram (see Figure 3.2 below) described by the WHO

(Woollard, 2006). People from both the policy making level and the administrative level were invited to participate in the in-depth interviews.

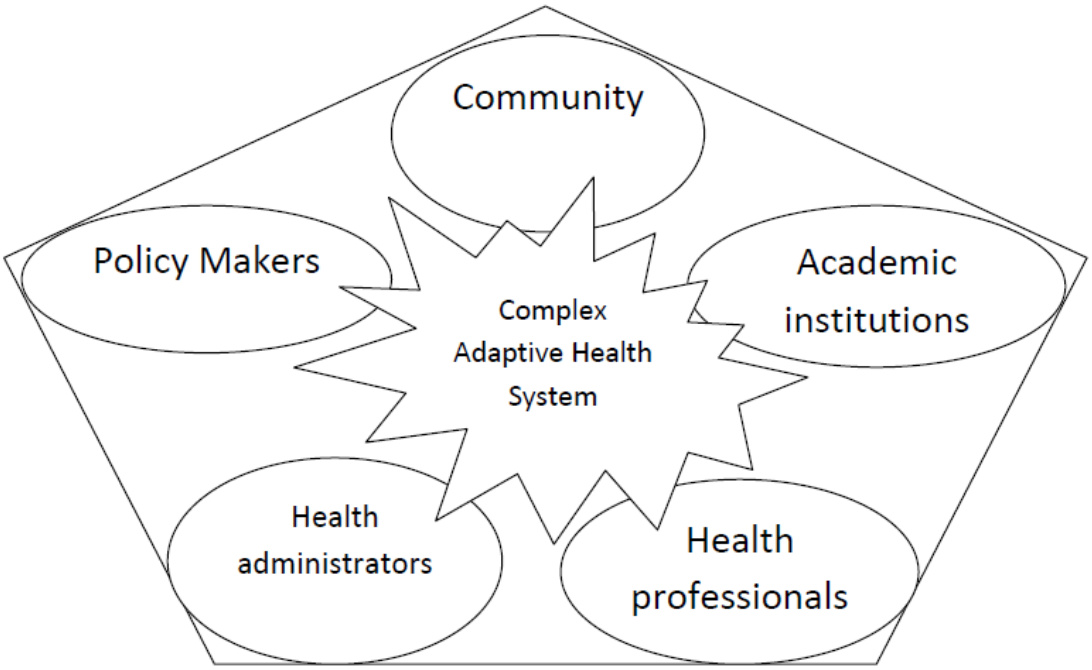


Figure 3.2 Social accountability partnership pentagram (modified from Woollard (2006)

Individuals were purposively selected to be interviewed. Twelve interviews were conducted with clinical academics who are leaders in the Wits curriculum at a professorial or senior lecturer level. All of the clinicians interviewed were in joint appointments with the Gauteng province or the National Health Laboratory Service (NHLS). Non-academic partners include a local government health manager from the City of Johannesburg, a provincial district manager and a district clinical executive from the North West province and an individual from a medical insurance company based in Johannesburg.

The interviews were conducted using a short series of questions to guide the conversation:

- What does the social accountability of medical practitioners mean to you?

- Tell me about the elements of this social accountability which have been part of the principles of your teaching over the years in the curriculum.
- What should the university do about developing socially accountable doctors in the curriculum?
- How can social accountability be developed and evaluated in undergraduate medical students?
- Do you think that you are socially accountable? What makes you socially accountable?
- Do you think that professional autonomy is a barrier or a support for social accountability?

Where the interviewee appeared to be unfamiliar with the concept of social accountability, they were shown a document which had both the WHO definition developed by Boelen and Heck (1995) and the definition used in The Training for Health Equity Network (2011) evaluation framework. This was then used as a stimulus for discussion of the ideas.

Data saturation was achieved at the end of this group of interviews. While the initial sampling was purposeful, theoretical sampling was done following preliminary analysis of each of the interviews in order to ensure that the concepts emerging were a recurrent theme.

3.3.5.4 Proposing a theoretical framework

A grounded theory approach was used in the preceding three parts of the study because it enabled the creation and evolution of a theoretical framework derived from data which were collected and analysed using qualitative techniques (Corbin and Strauss, 2008). The constant comparison of the views of participants in an iterative process was applied so that views were constructed into a general abstract theory (Creswell, 2003). This abstract theory was represented in a series of three graphic models.

Polit (2008) offers a description of the relationship between concepts, theories and frameworks. Conceptual frameworks, while abstractions, allow an understanding

of the relations between the concepts which emerge from the research as described by the researcher (Polit, 2008). This study uses the conceptual frameworks which emerge in the first three parts of this research to propose a descriptive theory which is described in the unifying framework presented in Chapter 8 of this thesis (Polit, 2008). This unifying framework may be described as a middle-range theory which explains the phenomena contributing to the advancement of social accountability (Polit, 2008).

3.3.5.5 The Experts' Reflections

Parse (2005) suggests that the evaluation of a theory has two facets, namely, structure and process. The history of the theory and its development, the foundational elements upon which it has developed and the relational statements which make sense of the concepts all form part of the structures of the theory (Parse, 2005). Amongst the features which reflect an appropriate process in the development of theory are semantic integrity and simplicity, coherence of the theory and its pragmatic use both in effectively guiding practice as well as further research arising from the theory (Parse, 2005).

In dialogue with Parse, Fawcett (2005) suggests that the criteria for an adequately developed and stated theory includes significance, internal consistency and both empirical and pragmatic adequacy. The latter refers to the utility of the theory in connecting the data to the theory and the relevance of the theory practice (Fawcett, 2005).

The nature of the emergent theoretical framework was guided by the principles outlined by both Fawcett (2005) and Parse (2005).

The testing of the theory was done through a national seminar. This seminar was conducted by the researcher and included medical education experts from medical schools in South Africa. These people were invited to participate in the seminar in order to interrogate the theory which had emerged from the first three parts of the study as well as the unifying framework. The seminar was recorded. The documents which were used for personal reflections during the seminar formed a part of the analysis of the seminar proceedings.

3.4 The researcher as person

I came to this study accepting that social accountability is a necessary dimension of a transformed health care system. I also began to realize that it was easy to limit the definitions and paradigms of this social accountability.

I was humbled through the engagement with the community participants. The communities' expressions of their vulnerability were a difficult concept to process and often required a revisiting of parts of the conversations. I was deeply affected by the levels of disrespect that the participants encountered with regard to their health care.

I have been closely related to students through ten years of coordination of the clinical programme. In that time, my relationships with many of them have been in the role as mentor or with those who have needed support of varying degrees. I approached the initial interviews in 2012 with a sense of expectation that the group of volunteers would provide an idealised way of being socially accountable. I was forced to rethink my own position and allow the participants to express themselves in the way they felt was best. The level of familiarity with the students often facilitated their deepened reflection on certain issues raised.

In the 2013 group of students, I was more restrained in the challenging of their positions than I had been the year before. This appeared to allow the groups a greater level of debate and contest than I had seen in the group in 2012.

My relationship with the partners in education varied from familiar and friendly to formal and professional. All of these conversations were easy engagements on the many issues that were raised.

3.5 Summary

This chapter discussed the research process and design which was undertaken during this study. The next three chapters present findings from the various parts of the study. These data are presented with an analytic narrative as well as supported by verbatim extracts from the research transcripts. These extracts are presented in italics in which the text may be bolded for emphasis placed by the

participants. The following chapters will describe the findings from the primary data collection as well as the conceptual models which emerged from the expressions of communities, students and partners in the education of doctors.

Chapter 4:
Community Concepts of Relationships and Expectations

4 Community Concepts of relationships and expectations

4.1 Introduction

This chapter discusses the findings which emerged from the data collected from communities in which the University of the Witwatersrand medical programme has student clerkships (See 3.2.5.1). A series of focus group discussions was held in two rural areas and within the Johannesburg metropolitan area. This chapter will outline the research procedures followed in these communities followed by a description of the participants in the focus group discussions. The findings extracted from the focus group discussions will then be presented in the form of a conceptual framework.

4.2 Research process

The study was conducted in communities associated with the undergraduate medical programme of the University of the Witwatersrand. The clinical section of the medical curriculum is conducted across three provinces in South Africa – Gauteng (which hosts the central and administrative campus), Mpumalanga and the North West province. The latter two provinces form the rural dimension of the clinical teaching platform.

In the North West province, the university has established a District Learning Centre in close cooperation with the provincial health authorities responsible for the adjacent Lehurutse Hospital. Students from a number of disciplines within the Faculty of Health Sciences send students on rotation to this site and during their stay in the area many of these students stay in accommodation attached to the district learning centre. Medical students may select Lehurutse as the site at which they will complete their Integrated Primary Care (IPC). The IPC clerkship is six

weeks long. Students are involved in a variety of community based activities during this clerkship during which much of the learning is led by nurses.

In Mpumalanga, the university has a rural facility which offers accommodation and allows multidisciplinary research in a site adjacent to the Bushbuckridge area. The local hospital is Tintswalo Hospital. The university has a significant research presence in the area through entities such as the Agincourt project. Students are allocated to a two week long compulsory clerkship for Public Health Medicine in their fifth year of study. The focus of this period is community based learning as well as exposure to cultural contexts of health in the area. Students are also taught the various levels of health care from district level to primary care. In their final year students may select the Tintswalo Hospital as a base from which to complete their IPC clerkship. The clerkship here is run in the same way at all the different sites.

The central academic hospitals associated with the university are located within a 15 kilometer radius of the faculty in Johannesburg in Gauteng, South Africa. The Chris Hani Baragwanath Hospital, the Charlotte Maxeke Johannesburg Academic Hospital, the Helen Joseph Hospital and the Rahima Moosa Hospital are the four main sites for learning in the discipline based clinical clerkships in the final two years of the programme. Students may also travel to more remote sites in the province for additional community based learning of health promotion. These hospitals and the areas around them may be characterised as the urban based training platform.

Focus group discussions were selected as the research technique to facilitate the participation of people who may feel marginalised by interview processes (Kitzinger, 1995; Madriz, 2000). The researcher decided that in the light of the nature of the anticipated participants, focus groups would enable different people to benefit from the interactions within the group to facilitate their expression in a discussion (Kitzinger, 1995). All of the group discussions were held in comfortable environments and refreshments were provided for all participants.

The questions which guided the discussion were as follows:

- Tell me about your experiences of and with doctors

- What do you expect as a member of the community of your doctors?
- What, if anything, do you know about the social accountability of doctors?
- Do you think that doctors should be accountable to communities? If so, how do you think this should happen?
- What do you think are the major health issues in your community?
- Do you think the doctors need to get involved in issues in the community?

4.2.1 Sampling techniques

A research assistant was identified in both of the rural areas to assist with the setting up of the focus groups. In the urban areas the researcher was assisted by contacts within the communities to set up the discussions.

A purposeful sampling technique was applied (Creswell, 2007). The two areas were purposively selected because the final year medical students may spend at least two weeks in each of these areas. Once the research assistants were fully briefed about the study, they were asked to select members of the community to participate in the focus group discussions. The only exclusion was that these participants should not be people in need of acute care at the time of the interviews. These group discussions were not based in a clinical environment and participants were not seeking care in any of the facilities.

4.2.2 Data Analysis

The focus group discussions were recorded and transcribed. The transcriptions were checked for accuracy by a process using the original audio recordings. These recordings and the transcriptions were kept securely by the researcher.

The data were coded starting with one or two group discussions depending on the location where these were held. In the rural communities, this was either after each discussion (Lehurutse) or after a pair of interviews (Mpumalanga). In the urban communities, the group discussions were more widely spaced.

Constant comparison was applied by analysing the data from the focus groups discussions either as single interviews or as a group of interviews from a particular

rural site. Emerging concepts were addressed in each subsequent discussion or group of discussions. This allowed for the modification of questions both in content and style of addressing these.

Initial coding of the data was done and the emerging codes were checked by a second researcher – in this case a co-supervisor for the study. Categories of data were then identified which were used in the final analysis of the data.

4.3 The community context

4.3.1 Rural Communities

4.3.1.1 North West

The first two focus group discussions were held in the North West province during November 2012. Invited members of the community came to the discussions which were held at the Lehurutse District Learning Centre. All of the participants in the first focus group discussion used public transport to get to the centre and were compensated in cash for these expenses. The second group which was made up of older women was transported to the centre by the researcher and one of the participants. Both participants and assistants in the research project were reimbursed for their expenses related to travel.

4.3.1.2 Mpumalanga

Three focus group discussions were held in this province over three days in February 2013. The first group comprised of eight traditional healers, the second was a group of ten people from a township area and the last was a group of eight people.

The first group discussion was held with the traditional healers in the building in which their local association meetings were held. The building was a modest structure constructed out of blocks with no plaster covering the outside of the building (See Figure 4.1). The building was serviced by a pit latrine about two hundred metres away from the building. The furnishings within the building were sparse with a series of benches, chairs and makeshift stools. A simple wooden table was placed in the centre of the room around which it was expected that the

interview would be conducted. There was no covering over the minimally plastered floor in the room. The striking feature of the décor of the room was the framed copy of the “Charter for Positive Values” on the wall. This charter was authored by the Moral Regeneration Movement of South Africa in 2001 as part of a national movement to redirect the moral values of society (Moral Regeneration Movement, 2001). The document on the wall highlighted the nine values of the charter which sought to govern a way of life in South Africa (see Table 4. 1).

Table 4.1 Charter of Positive Values

Charter of Positive Values
Respect human dignity
Promote Freedom. The Rule of Law and Democracy
Improve material well being and economic justice
Enhance family and community values
Uphold loyalty, honesty and integrity
Ensure harmony in culture, belief and conscience
Show concern and respect for all people
Strive for justice, fairness and peaceful coexistence
Protect the environment



Figure 4.1: The office in which a focus group was held with traditional leaders in Mpumalanga

The second focus group discussion was held in a local church in the Malatuleng village. The church building was a simple structure with the name of the church over the front entrance. The ornate plastic seating inside the church was rearranged in anticipation of the discussion which we were to have there. A single pole decorated in white supported the roof overhead. There was no ceiling. A bright red curtain formed the backdrop behind a lectern which was the position from which the preaching was done on Sundays. The seating was arranged in a circle around a table (See Figure 4.2). Two of the participants were wheeled in to the room in wheelchairs. The greetings were effusive and the welcome to the researcher was warm. The only man who would participate in this group was the pastor for this church community. The unit was served by an outside pit latrine.



Figure 4.2: Mpumalanga participants shown gathering in a church where a focus group was held

The remaining group in this area was conducted in the boardroom of the research entity associated with the university within the hospital grounds. I was already seated and ready when the group arrived. It was made up of predominantly younger people, all of whom were articulate and able to engage the discussion effectively.

4.3.2 Urban communities

4.3.2.1 Boipatong

The focus group discussion held in this area was held in a building under renovation as a planned extension for the adjacent health outpost. The planning for the group was to hold a single small group discussion. However, twenty people responded to the call by the clinic's registered nurse to attend the discussion. Despite the group being very large I decided to go ahead with the discussion so

that there was no obvious selection of who may stay to participate in the discussion. I felt that attempting to separate people would cause an unpredictable effect on the ensuing discussion. As it proceeded, there were challenges during the interview in getting all those present to participate. The data collected from this group was retained in the data corpus because many of the views expressed were a confirmation of views which had been raised in previous groups. A concept which emerged for the first time was the impact of environmental conditions in illness which received overwhelming confirmation through agreement of the larger group.

4.3.2.2 Westbury

Westbury is a township on the western side of Johannesburg about 10km from the Wits Health Sciences campus. The community is a lower income area which over the years has been characterised by crime and gangster violence (Dannhauser, 2008). In research on spatial justice, Westbury is characterised as being built without consideration for the issues which create a growing and vibrant community for its more than 15 000 inhabitants (Chapman, 2014). One of the central teaching hospitals, Rahima Moosa Mother and Child Hospital is located on the southern border of this community.

The focus group in this community was conducted in the lounge of one of the participants' homes.

4.3.2.3 Alexandra

Alexandra is a township on the north of Johannesburg about 20km from the central health sciences campus. The township was established in 1912 and has a long history of association with the university through health service delivery.

This group was made up of eight participants and the discussion was held in the library of the local primary school.

4.4 Demographic data of participants

Table 4.2 describes the general demographics of the participants in the focus group discussions. The order represents the order in which the group discussions

were conducted. The group assigned is a label which will be used to denote the group from which particular comments are drawn in the final analysis of the data.

Table 4.2 Demographic characteristics of community participants

Order	Group	Site	Average Age (years)	No of participants	Male:Female
1	Rural 1	Lehurutse	25 (23 – 30)	6	3:3
2	Rural 2	Lehurutse	40 (20 – 57)	12	All female
3	Rural 3	Mpumalanga	58 (46 – 71)	8	3:5
4	Rural 4	Mpumalanga	65 (40 – 94)	10	1:9
5	Rural 5	Mpumalanga	25 (21 – 40)	7	1:6
6	Urban 1	Boipatong	43 (21 – 70)	20	5:15
7	Urban 2	Westbury	61 (37 – 78)	10	1:9
8	Urban 3	Alexandra	49 (30 – 72)	8	4:4

The first group held in Lehurutse had an average age of 25 years. All, except one of the participants played a role in the community, either as a youth organiser or a community representative. One participant was unemployed while two others were radio presenters; another was an administrator in a youth office while the remaining two worked as community organisers.

The second group was characterised by being all female. Seven of these participants were unemployed, one was a student at the local college and another was a traditional healer while the remaining three were employed as care givers of either children or the aged. Five of the women in this group described themselves as mothers despite this information not being specifically requested by the demographic data sheet.

The next three groups were held in the Mpumalanga region. Group three comprised eight traditional healers, five of whom were women. Two of them were unable to read and write and were assisted with the informed consent process by the research assistant. Group four hosted the oldest participant at 94 years of age. The male in the group was the pastor of the church in which the focus group

discussion was held. Seven of the participants were pensioners with the youngest participant (40 years old) having been disabled by a stroke. One of the participants listed her job as caregiver to an older person. In group five, the average age was 25 years because a single participant was aged 40 years and listed his job as community youth project coordinator. The average age without this participant was 22 years. However, judging from the interactions between this older participant and others in the group his age did not impact on the group dynamics. Three of these participants were students and two others worked in the youth sector. The remaining two were unemployed.

Group six held in Boipatong had 20 participants as a result of a miscommunication discussed above. Fifteen of those who participated in the discussion were unemployed while four were pensioners. Only one participant described himself as a counselor.

In the group held in Westbury, the average age was 61 years. Three people described themselves as housewives. Another four referred to themselves as drawing old age pensions while an additional two participants were retired. The remaining participant was 42 years old and was unemployed at the time of the group discussion.

The final group discussion was held in Alexandra with seven participants, three of whom were unemployed. Two participants were pensioners and another was a retired school teacher. The remaining two worked as a primary health care worker and a volunteer at a local outreach centre.

4.5 Findings of the community study

Eighty one people participated in this community part of the study with many of these participants being unemployed (22 participants) and/or dependant on one of a variety of state pensions (24 participants).

The discussions in the focus groups were guided by a set of questions in order that the main areas of interest in social accountability were addressed. Community participants engaged freely on the various questions but often in a random manner which did not follow the order of the questions initially posed.

The community members in the initial discussions were unable to articulate an understanding of social accountability as defined in the WHO documents (Boelen and Heck, 1995). Instead, these community participants were able to express a series of expectations of the individual doctors who managed their health and the system in which they carried out this action. They did not seem able to exact the accountability in their individual personal relationships with the doctors. The guiding questions assisted the groups who were then able to discuss social accountability framed in terms of experiences of doctors, the participants' expectations of doctors, and their ability to exact accountability. Participants also reflected on their perceptions of the health priorities facing their communities and the doctor's role in addressing these.

The four main categories which emerged from the initial coding of discussions with these community members are best captured as follows:

- The consultation as a place of love and respect

  When I come to the doctor, I have an illness problem. I want to get here, sit down and the doctor listens to me and then after listening if the doctor does not understand what I'm saying then he can have all the apparatus they use to check me as it is necessary for him, with care and love (Rural 2).

- Interactions of social conditions and health priorities

  You know poverty causes a lot of things; stress, unhealthy decisions … we don't eat healthily; it causes some issues of disease inside of you. So most definitely I think poverty plays a big role (Urban 3).

- A system of many parts and different actors

  … the doctor alone will have to suffer the consequences of the (ill) feelings of patients but let's not forget that it is from the receptionist... it goes to the auxiliary nurses, ... it goes to trainee nurses, then you finally go to the doctor (Urban 3).

- Teaching ubuntu as community engagement

… as much as they study medicine they must study people and the community (Rural 1).

4.5.1 The consultation as a place of love and respect

In both rural and urban focus group discussions there was an appreciation for the individual encounter with the medical practitioner. The participants shared wide ranging experiences of their encounters with doctors from those who had very positive experiences of healing (*I am happy the way the doctors treated me, I am healed and I am alive – Rural 3*) to others who were left disillusioned by their encounter (*I feel like they have failed me because even now I don't know what is primary amenorrhea … because I don't have information about primary amenorrhea* – Rural 2).

The perceptions of the participants distilled into three main aspects relating to the consultation – matters pertaining to the doctors' behaviours and attitudes, the patients' behaviours and attitudes towards the doctors and the space between doctor and patient.

4.5.1.1 Doctors' attitudes and behaviours

Doctors' attitudes and behaviours determined the experience of the community participants in the majority of the consultation encounters. There were strong opinions expressed in all of the focus groups across rural and urban domains. Many of the participants had very positive healing experiences with doctors and these were characterised by the time taken to provide clear explanations of the illness presented:

They explained to me and they made you feel comfortable. I think you need to feel comfortable with a doctor (Urban 2).

Participants reported that this comfort often derived from a pleasant demeanour shown by doctors in the initial phase in a consultation which allowed patients the ability to express themselves more freely.

> *I can be happy when I consult a doctor who shows some smile on her face, though I am illiterate, I can try my best to communicate with her freely because I can see this person is happy (Rural 3).*

There was a general appreciation of the work that doctors do with heartfelt expressions of joy at being healed from particular ailments. The participants' best experiences were when the doctor treated them with particular care sharing their own personal struggles in helping that participant resolve a stressful situation, when the doctor felt like a part of the patient's family or when the doctor had treated the patient like a brother. There was an appreciation amongst the participants that the consultation is often not about the medications dispensed or about absolute cure:

> *Sometimes when we go to the general practitioners you come back healed even though you were not given treatment, the conversation I have with the doctors, (it) helps me to be healed without any treatment (Rural 2).*

There was, however, a pervasive view that the consultation should be more of a place of love and respect. The perceptions of the participants across all domains was that doctors' attitudes and behaviours lead to negative experiences in the encounter with the health care system. There were many reports of rude and unwelcoming treatment by doctors. Participants described instances of inadequate examination, investigation and referral to higher levels of care in the health system. As a result of the inadequate consultation, participants reported that they often felt unconfident about the assessment made and management given for the ailment with which they presented. Participants often felt disrespected by the doctors especially with regard to their questioning of decisions made regarding their care. There was also a perception that there are differentials of care between those who are connected with individuals within the health care system and those who may not know anyone. Of particular concern was the expression that patients who are dirty may be discriminated against.

Perhaps these experiences are best captured in the following comment by a rural participant:

The doctors nowadays, they do not take time for patients. They are rude. They don't use Batho Pele[3] *principles – privacy, confidentiality of the patients (Rural 2).*

Despite these experiences there was an overwhelming accommodation of the doctors' behavioural lapses by apportioning blame to other staff members or to an inadequate health system. Nurses were the target for some of the blame through the lack of attention to detailed translation in the consultation or not providing a regular chaperone when doctors were consulting. The shortage of doctors was often blamed for the impatience and frustration for doctors which manifests in inappropriate behaviour towards their patients. An urban participant described it as follows:

….it's one doctor with thousands of patients, so doctors get impatient here and then she (the doctor) has a bad experience with ***the first patient*** *and then the rest comes, you know, when the rest go ….Aai!*[4] *they get it from her (Urban 2).*

These kinds of responses by doctors to the pressure of work are reportedly less marked in the private sector. The extract ends with the expression that the doctor's conduct is punitive towards the patient. Participants perceived a marked difference in the behaviours of doctors between the public and private sectors. While waiting in queue at a private surgery was accepted as a sign of the doctor being a good clinician, in the public sector it is perceived as poor service delivery. There are stark perceptions of the public – private divide as many participants had encountered doctors in both these sectors, often the same practitioner who demonstrated very different behaviours in the two different environments. This experience was mentioned more commonly in rural areas as reflected by the following:

[3] Batho Pele (a seSotho word meaning people first) refers to a government quality improvement initiative launched in 1997 to address eight principles: consultation, service standards, access, courtesy, information, openness and transparency, redress and value for money. These principles translated into the health domain emphasise professional ethics, confidentiality, outreach, effective complaints procedures and adequate systems information, amongst others.

[4] Aai – a vernacular expression of emphasis commonly used in all South African conversation.

The doctor does a proper examination when you visit them at their (private) surgeries and they are very good there, but when you find him at the hospital he is different and he don't care (Rural 4).

The participants ascribed these differences to the greater financial benefits which accrue in the private sector. Participants perceived that money was the motivation for doctors leaving the public sector to work in the private sector, even though the pressure of a poor health system may drive them out. Money was often seen as the antithesis of caring and there was a sense that the lack of direct financial incentives for the public sector doctors was responsible for their *slacking on their job (Urban 2)*.In general, the largely positive experiences in the private primary care sector were perceived to be because doctors were *empathetic and understood people and took time (Rural 2)* and that you will *always find a doctor there (Urban 3).* It appeared that in the private sector doctors were prepared to attend to patients without consideration for their scheduled breaks in a working day whereas those in public sector services were committed to taking the breaks regardless of how many patients may be waiting to be attended.

This behaviour represented one of the areas which participants identified as causing their negative experiences and yet was one that is often not challenged by the participants.

The inability to challenge doctors was reflected in the following comment:

I, as a patient, am afraid to confront the doctor. You (the patient) put him on a pedestal, right. ***He knows****.* ***He studied*** *medicine… like a lot of them will tell you, they studied medicine, so you mustn't tell them what to do or what's wrong with you (Urban 2).*

The fear felt by patients was a recurrent theme in the expression of the inability to challenge doctor behaviours by all of the groups. It appeared to arise from two main dimensions, namely, the power of the doctor as knowing all and the fear of victimisation. The power which is afforded the doctor through education is felt by the patient. Participants expressed this power through a couple of evocative images:

I am pleading. I am here as a sick person, I am ailing and I need him to help me. He is my godfather at that moment (yeah, yeah in agreement from group) because this is his practice, that is his kingdom (Amen from the group). He's got the whole authority in any way (Urban 3).

So in that way you would be my life supporter as a doctor. I would depend on you to come back and say hey dog this is happening or that's not happening and this is suggested that we should do (Rural 1).

The two images of godfather (from a Mafioso paradigm) and life supporter (as in dependency) reflected the comments of many of the participants of their experience of doctors. There was a sense of the ultimate power which resides in the doctor which renders the patient completely dependent and yet vulnerable.

The fear of victimisation prevented any substantial challenge to inappropriate behaviours by doctors because you are *scared to ask because the way he treats you, you don't like, because you will be angry and you won't feel okay in your spirit* (Urban 1) and also *if you tell a person you are wrong...when you come next time, they don't help you with love* (Urban 1). Both of these comments reflect the pervasive view of the inability of community participants to challenge doctors and the widely experienced fear of professional reprisals.

4.5.1.2 Patients' behaviours and attitudes

Despite this sense of dependency and fear, there was a recurring expression by the participants reflected by *this is suggested that we should do* (Rural 1) which frames their general willingness to collaborate in the development of solutions for both their personal wellness and the development of the community. Community participants suggested a broader community involvement in the management of the health facility problem areas.

There was an acceptance that patient behaviours may contribute to the negative experiences within the health system. These include lack of adherence to prescriptions as well as the impatience with other patients who may require additional attention from doctors at a health facility. There was an impression that many patients do not listen and may behave inappropriately after being treated.

Participants expressed the perception that some patients may also have unrealistic expectations of doctors wanting to be treated like an *early laid egg (Urban 3)* implying an expectation of deferential treatment by the doctor.

There was also a perception that many things should be handled by the patients themselves before they need to attend a doctor.

> *Doctors, the one thing they should be doing, is to alert the community for the community to take responsibility to take care of themselves (Rural 5)*

4.5.1.3 The space between patient and doctor

The meaning of their interactions with doctors was expressed by the community participants as being founded in the quality of the relationship which they are able to establish between each other. There was a profound recognition of processes occurring in the consultation which are not limited to the exchange of medical information. For these community participants, the space between the patient and their doctor is occupied by interactions which manifest their pain and fear, their need for love and respect, respectful communication, ubuntu and spirituality.

There was an overall deep appreciation of the role of doctors in the lives of these participants. As patients, the approach to the doctor is often accompanied by fear both for the disease process being experienced as well as the encounter with a doctor who may not be welcoming in the consultation. This attitude of welcoming was echoed through many of the discussions and was often reflected as needing to be more respectful and loving. The dynamic definition of love within the consultation was captured by the following two comments:

> *Love is when you get a treatment and the doctor explains it in the way you understand it (Rural 5).*

> *You see they are supposed to touch with love, touch with... because..eish[5].. inside (the body) it's very dangerous (Rural 2).*

The dangers and fear associated with illness appear to be ameliorated by the interactions between the doctor and the patient. If the doctor appears to welcome

[5] Eish is an exclamation used in South Africa for a variety of expressive moments from sad to joyful

in a particular way, then there is an increased sense of freedom expressed by the participants to reveal themselves more completely.

The rural communities expressed this idea most frequently:

> *You would find in (a) situation where the patient is going to look for help from the doctor they feel intimidated by the fact that they are with the doctor. More than anything else they are afraid that openness is not there or the doctor does not give that room to the patient to feel they can be open (Rural 1).*

> *... if you come to the doctor sick, there is a counselling that you need. I'm not saying that every patient must be counselled. This doctor will still give me counselling with communication, so that you can feel free and express and tell the doctor everything what's the problem (Rural 2).*

The communication between the doctor and the patient was perceived to be influenced by the high esteem in which the doctor is held by the community and the attitude which the doctor takes on in the consultation. Ubuntu[6] has been lost over the years in the engagement with doctors. Participants understand ubuntu as being *to have humility. To know that you are dealing with a human being who is not feeling well and you are there (Urban 2).*

This spirit of ubuntu was first expressed in the early focus group discussions and then recurred in most of the subsequent discussions. There was a coupling of this idea with the expression of spirituality which appears to enhance the quality of the consultation. The length of time which doctors spend with patients in the consultation appears to be a manifestation of their dedication to their work and is often seen as a dimension of spirituality.

4.5.2 Interactions of social conditions and health priorities

An institution's response to the health concerns or priorities of the community or region which it serves is an important part of its being socially accountable (Boelen and Heck, 1995). In their reflections on the health priorities for the respective

[6] Ubuntu is an African philosophical concept of a communitarian way of life governed by the maxim "a person is a person through other people".

communities in which the discussions were held, participants placed the priorities in two main groups: a list of biomedical conditions and a list of psychosocial situations.

The main biomedical conditions which were seen as priorities across all communities are hypertension, diabetes mellitus, stroke, HIV and related sexually transmitted infections, tuberculosis, cancer and substance abuse including alcohol to which they linked the high prevalence of crime and violence. One community related the industrial environment in which it is located as being a major contributor to the illnesses which are seen in that community. The high rate of teenage pregnancy is also a problem in some communities.

Participants described in some detail that social conditions play a significant role in their illness. Unemployment and the consequent poverty contribute to much of the disease in a community. The views of many of the participants are best expressed in this statement:

> *You know, poverty causes a lot of things; stress, unhealthy decisions (another participant mutters "definitely), all of these things and we don't eat healthily, it causes some issues of diseases inside of you. So most definitely I think poverty plays a big role. (Urban 3)*

Some of the participants perceived that many of their problems arise out of a health system which does not address their needs adequately, in particular, the need for increased numbers of doctors. Within the health facilities, there are problems relating to the adequacy of supplies and equipment (the latter especially true in rural discussions).

There is a role for both doctors and communities in addressing these priorities. Communities accepted responsibility for many of the problems they experienced:

> *Behavioural patterns, our lifestyles, we are corrupt, too corrupt. Err... too much of alcohol **...** too much of alcohol and too much of drugs, and we smoke a lot of cigarettes and marijuana amongst others. Err conflicts, conflicts in the yards, personal conflicts in the home, conflicts in the yards*

that eventually bring about stress and stress will distribute a number of illnesses. (Urban 3)

This idea of communal responsibility recurred in many of the conversations and extended to the acknowledgement that there is a high level of ignorance in the community which allows the negative situations to persist. In particular, communities expressed their concern over the growing awareness of the causes of transmission of disease especially HIV and their experience that people do not take adequate precautionary measures.

Arising from this acknowledgement of ignorance, there was still a sense of taking responsibility for resolving the challenges facing the community:

I do not think that it's the problem of doctors because we as the community, it's us who cause all these things. We have to deal with these issues as a community. We need to just sit together and try to educate one another concerning those things, therefore maybe it would be resolved somehow, some difficult issues (Urban 3).

The idea of co-responsibility with doctors emerged from this discussion that doctors may not be able to cure all the illnesses they present with, but that they may have a role in educating the communities within which they work. This education is not limited to the patient – doctor interaction but is part of a family based education to facilitate the care of a chronically ill person in the home.

There were mixed attitudes towards the doctor's role in the community regarding the health priorities identified by these community participants. There was a strongly expressed expectation of their role in patient education both in the encounter with the individual patient as well as within the broader community through workshops and other engagements which *create a good communication space between themselves and the community (Rural 1)*. Different forms of education are the vehicles for community control over their illness or health as described by the participant who was taught how to treat hypoglycaemic episodes experienced by the person in their care. This education may also serve to change the community's help seeking behaviours.

Other participants felt that the pressure of the work in the hospitals made excursions into the community too demanding. There were also varying perceptions of the extent of involvement in the community with some expecting that doctors should contribute to community activities and others that their social involvement may lead to a greater understanding of the community in which they serve. There was a perception that doctors are the *life source of the community (Rural 1).* As such, there was a call for doctors to take a role in representing the needs of communities in local government discussion processes.

4.5.3 A system of many parts and different actors

The experiences of the participants in their contact with the health system varied with many groups differing on whether these were predominantly positive or negative.

Many were grateful for the healing they receive in the health system acknowledging the good standard of immediate and emergency care, but their most profound positive experiences were expressed when they were able to see the same doctors on more than one occasion - the continuity of care.

> *You are **very** lucky (General agreement, Jah, Jah, jah,) **very lucky** (huge emphasis) if you meet the same one (Urban 2).*

The opposite of this appears to be the frustration of seeing new practitioners on each visit and the inadequate follow up despite promises of being called back to a facility for this.

Participants revealed a deep understanding of the health care process as a system which depends on the adequate function of the many role players. Despite their recurring criticism of the conduct of nurses, they ascribed an important role to them as the motivators of the doctors, the translator of patient needs and the accompanists in the consultation encounter. As noted before, they perceived the quality of their encounter with the health system to be dependent on all levels of personnel within a facility – the security guard at the entrance, the administrative receptionist who received them, the cleaners, the professional students learning in

that environment, nurses, doctors, pharmacy and laboratory staff who served that facility.

Waiting times in the public health system were seen to reflect the shortage of personnel especially doctors while in the private sector these were seen to reflect the quality of care delivered.

This idea of a system was continued in their understanding of the various processes responsible for the adequate delivery of medical supplies and equipment to the health facility especially in the rural areas. They showed appreciation for the referral processes and often had more positive experiences at the higher levels of care in the system.

Following the earlier reflection on the principles of Batho Pele, it is noteworthy that there was little confidence in the current methods of exacting accountability through complaints procedures.

> *In the public clinics there are suggestion boxes as well but people believe that those suggestion boxes are checked...those suggestion boxes don't go to the higher authorities to check their complaints, the clinic itself checks the suggestion box and removes the bad letters and selects which ones to send through (Urban 3).*
>
> *We have indicated the grievances we have in a suggestion box. It seems that they open these suggestion boxes and check them, read and then they throw them away. We write the issues we have but nothing changes, the suggestion boxes are only opened. And then last year they started locking the suggestion box, community members were the ones with access to opening the suggestion box. (Rural 2)*

The acknowledgement of community involvement in a change process is important and community participants suggested this in other discussion groups. They were willing to use the current procedures but expected a greater level of responsiveness. The systems approach which they reflected expects that all levels of the system be addressed by the management levels within health facilities.

4.5.4 Teaching ubuntu as community engagement

Participants did not perceive a strong and vibrant relationship with Wits University in their communities. In only one rural discussion, in an area where the university has a long research based association, was there a clear understanding and appreciation of the role of the university. In that area the contribution made by the introduction of medical students to the area for their learning has had a positive effect, particularly on the traditional healer practitioners:

> *We (traditional healers) appreciate Wits for sending the medical student(s) into our rondavels[7] because this makes us to work free because we all know that a traditional healer was suppose(d) to hide in the rondavel always but now we have come out of our rondavels so that everybody can know us because of Wits. When we visit the hospital we have a good relationship now because they recognize us also as human being(s) but before, if they can see you with the beads on the hands and neck they will shout at you saying that those beads are the ones makes(sic) you sick (Rural 3).*

In other areas a variety of activities were seen as proxies of the university being involved. The presence of a vehicle with the university emblems and the occasional visits by research teams into an area are two examples. One community spoke of such a research event and concluded this by saying that the care which this demonstrated was tempered by the feeling that university people were *afraid of walking in the streets, of walking alone (Urban 2)* in a particular area which limits their impact within that community.

By far the greatest impression the university makes is through the presence of students from a variety of professional degree programmes. In one of the rural areas, the students' participation in home based care was appreciated and their clinical work helped to reduce the waiting times for patients. In an urban context, the community seemed to disregard the students as only being there for their clinical practical. There was a call that students become involved in community

[7] Rondavels are a traditional South African dwelling structure which is either round or square and thatched depending on the cultural background of the community in which they are constructed. These structures have become part of modern construction over the years.

health campaigns as volunteers. One of the communities adjacent to a central teaching hospital was unable to connect the clinical staff at that hospital to the Wits academic platform. They appreciated the treatment by professors but did not see the direct connection to Wits.

Communities offered clear pointers about the need for particular content to be included in the teaching of medical students.

> *I was thinking about at medical school when you are teaching these doctors you need to teach them ubuntu as well so what they know what to do when they come to communities (Rural 2).*

The concept of ubuntu which earlier was a template for professional behaviours was expressed as being an important part of the curriculum. This was further reinforced through students getting to know communities on different levels. This was well captured in the following:

> *I think in as much as they study medicine they must study people and the community (Rural 1).*

Many participants felt that medicine was a calling and as such the student arrived at medical school with a particular attitude. However, there was a strong mandate that the teaching to which they were exposed needed to deepen this sense of ubuntu – seen as important for their future practice:

> *Somewhere in their training they must ... and even if it's like six months or what... just concentrate... I feel strongly that they must be taught. (Murmur Mmm. Jah, Jah,) you cannot do something if you have not been taught.* ***So they must learn it.*** *(Urban 2)*

Participants suggested actions by the university in which they could cooperate with the community in various programmes. They also suggested that students could be exposed to different levels of care which would deepen their learning experiences. In particular, there is a need to network with nongovernmental organisations already active in communities to increase effectiveness of programmes.

4.6 Emerging Concepts

Ubuntu is an embracing concept which defines the community's engagement and expectations. Within this global social dimension, the doctor's relationships with the individual patient and the broader community are a central concept which emerged from these categories. The iterative dynamical interaction between the patients and their doctors enhance the reflection on how a community may function more effectively. The doctor – patient relationship is characterised by the concept of vulnerability in the face of the power dynamic which exists between the patient and the doctor. The vulnerability of patients, often themselves marginalised, is one end of a continuum. The opposite end is an environment in which the people can exercise their human rights to a greater extent than is currently reflected in the data. The rights of the patient exist within a tension with the concept of co-responsibility between the patient and the community on the one hand and the practitioner on the other. This shared responsibility is the pinnacle of a dynamic continuum which acknowledges the power vested in the individual practitioner through their education and status and the need for the empowerment of the community to take responsibility for their community and its wellbeing. An expectation arises that doctors should use their power responsibly while the community takes more responsibility for social development.

The concept of a dynamic gap between rights and responsibility suggests that there is a space between these ideals. Occupying that space between is the concept of healthy relationships between all the players in health care which ensures care which goes beyond the biomedical encounter with disease. It is this space between which may be characterised as a complex system where the determinants of the relationships between players in the wellbeing of people are dynamical and need to be open rather than linear. It is this space between which allows us to look at the relationships between people beyond a linear causality model (Suchman, 2006).

The idea of the various dimensions of ubuntu in a national context are represented in the graphic (Figure 4.3) below and the discussion which follows explains the conceptual framework.

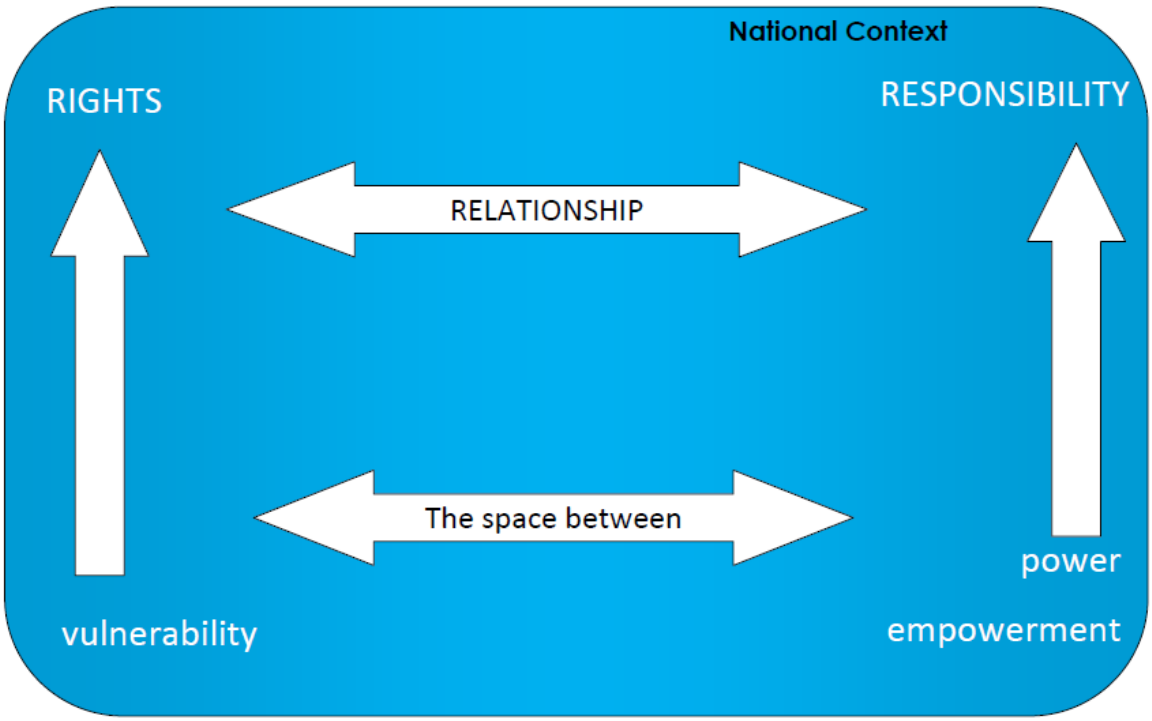


Figure 4.3 Framing ubuntu as a national context

4.6.1 Conceptual framework of the community concepts

The discussion which follows places the framework in the context of the experiences of communities. The model has a triangle at the centre which characterises the stable existence of a community. While this community of reciprocal relationships may thrive or struggle at varying stages of its development, it remains the basic unit in which the wellness of a people can be grown. It represents the local community reality. This triangle is then inserted into a regional reality where the interaction of larger systems is evident. Both of these constructs are inserted into a national context whose goal must be the achievement of a long and healthy life for all its citizens.

4.6.1.1 National context

Ubuntu is an overarching concept which defines the communal national space. Three fundamental paradigms exist within the continuum of ubuntu. These are the rights and responsibilities of the actors within a health care context, but both of these are in constant tension with each through the relationships which actors in

the system have with each other. Rights as an end point are enjoyed as the counterpoint to the vulnerability experienced by people in their relations with doctors and illness in general. The power that doctors exert and the empowerment of communities are the starting point for the journey towards sharing responsibility by doctors and taking responsibility for communities.

4.6.1.2 The village and township dynamic

The community of reciprocal relationships is at the heart of this complex adaptive system in which township or village realities interact with other social systems. The community is the defined area in which the people live and in the ambit of this study represents either an urban township space or a rural collection of villages (See Figure 4.4). The relationships within these communities are reflected in its members who may be seen as patients (in their illness) or as citizens (in their wellness). The doctor is seen as one of these citizens within the community called to a particular level of interaction. While both the doctor and the patient are members of the community, they interact most intimately in the vulnerability of the consultation – that place of love and respect. It is this two way iterative relationship which is the key to the creation of well being.

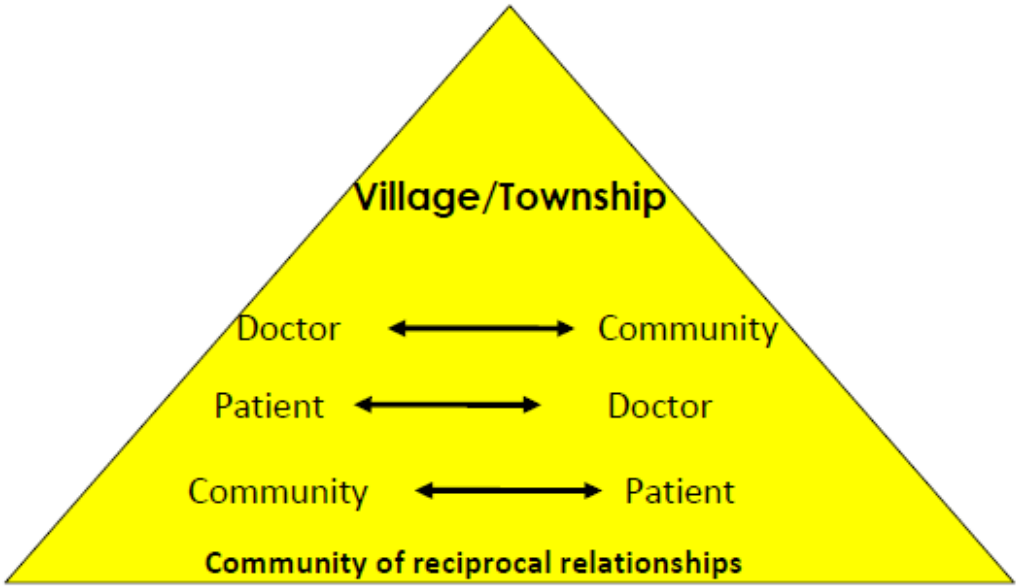


Figure 4.4: The community of reciprocal relationships

The doctor and patient represent an important two way relationship which is deeply influenced by the nature of the community. Other relationships may be at play but few will have as great an impact in this dynamical community of reciprocal relationships.

4.6.1.3 Regional mediating systems

The tension between the local and national contexts is mediated to some extent by the health and education systems which occupy the space between the two levels. These systems represent a dynamical relationship between the social determinants of health and the systems of health and education. All of these interconnections experience the same tensions between rights and responsibilities as well as the pressure to move from vulnerability to rights through a change of the asymmetrical power dynamics to the emergence of co-responsibility. The graphic below (Figure 4.5) highlights poverty and the breakdown of communal values as being the central social determinants of health. On the positive side the health system has declared itself as a proponent of the principle of “Batho pele” – people first. This idea may be carried forward by the education system through a more empowering community engagement. The boundaries between these three concepts are open and porous promising new emergent patterns for addressing the achievement of wellness.

This final graphic (See Figure 4.5) demonstrates ubuntu as a communal philosophy in the national context at the centre of which is a community of reciprocal relationships mediated by the systems of health care delivery and the associated education.

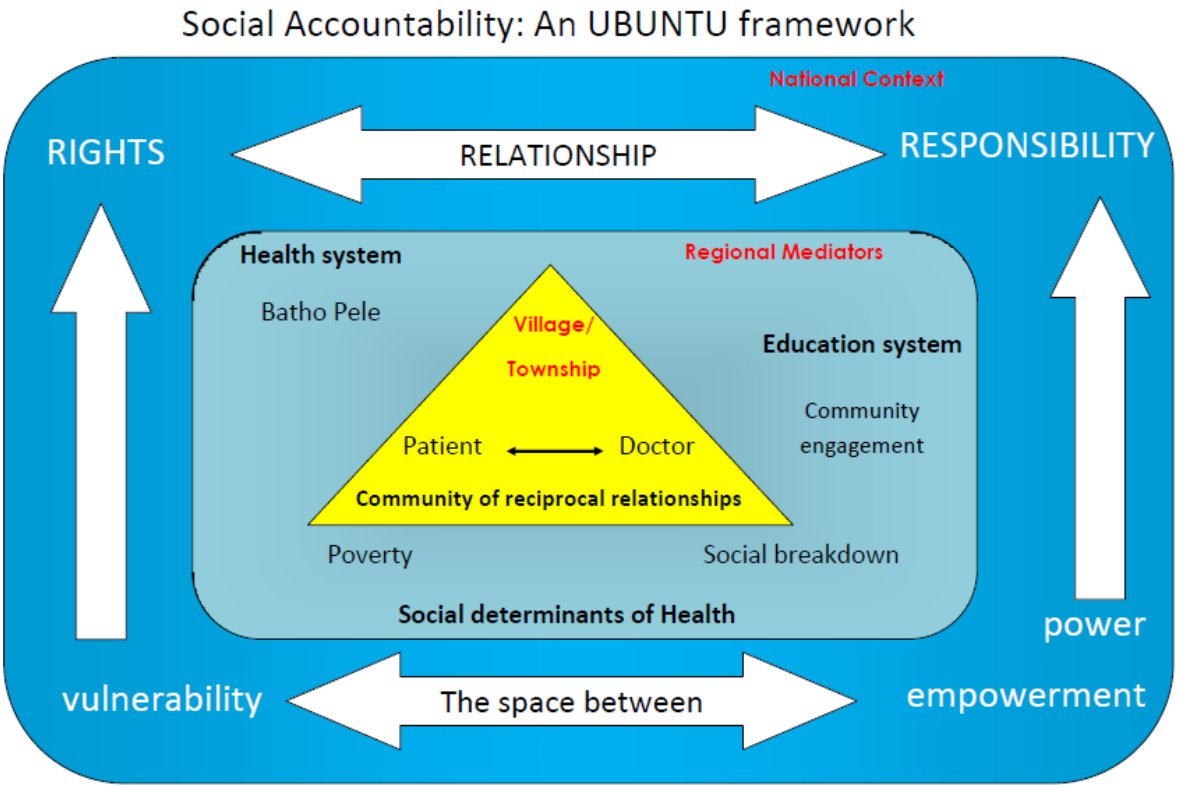


Figure 4.5: Social Accountability – an ubuntu framework demonstrating the relationships between the local and national contexts

4.7 Summary

The findings of the study of social accountability as perceived by communities associated with the Wits undergraduate medical programme revealed four categories, namely, the consultation as a place of love and respect, the interaction of social conditions and health, a system of many parts and different actors and teaching ubuntu as community engagement. These categories facilitated the emergence of concepts of rights and responsibilities in relationship with each other in the broader paradigm of ubuntu. The emerging concepts of vulnerability and empowerment of communities form part of the engagement with communities. The education and health system span all of these concepts and both relate to communities in an erratic manner. It is in the centre of this community that doctors and patients relate in a dynamical interaction.

The next chapter will discuss the findings of the student discussions of social accountability.

Chapter 5:
The Vision of Students

5 The vision of students

5.1 Introduction

The previous chapter reported the findings from focus group discussions held amongst communities associated with the MBBCh curriculum at the University of the Witwatersrand (Wits). The conversations with the community participants framed their experiences of social accountability in terms of relationships which are characteristic of an ubuntu communitarian context. This chapter will report the findings from the focus group discussions held with students from the graduating classes of 2012 and 2013 at Wits. This chapter describes the study context; the methodology employed in this part of the study and the findings, followed by a description of the theoretical concepts which emerged from the student data.

5.2 Context of the student study

The University of the Witwatersrand transformed the MBBCh curriculum in 2003 guided in part by the international movement to produce medical graduates who were more than the sum of their accumulated factual knowledge (Zwi et al., 1994). Zwi et al. (1994) urged the revitalization of South African medical education through the adoption of curricula that improved the graduates' understanding of health in its broadest social context as well as their ability to function within the health system. These ideas have gained currency over the years and have been further emphasised in the Lancet Commission report which focused on the graduation of doctors who meet the needs of the community and health care system (Frenk et al., 2010).

The Wits curriculum embarked on a number of innovations in teaching and learning not least of which was the introduction of a problem based learning process (PBL). The innovations sought to deliver a medical graduate with four

main core competencies: provision of patient care in plural health and social contexts, developing and delivering appropriate care extending beyond the acute presentation of illness, delivery of effective care enhanced by cultural safety and social awareness as well as the competency to deliver primary care in defined geographical communities (University of the Witwatersrand, 2003).

The new curriculum allowed for a dual admission route into the degree. These were either as direct entrants from secondary school or after completing a basic degree, as graduate entrants. School entrants complete the first two years in a traditional basic science curriculum. They are joined in the third year of study by graduates from a range of possible undergraduate degrees who have demonstrated competencies in some of the basic sciences. The two admission streams study together for the final four years of a single curriculum (MBBCh III to VI). MBBCh III and IV are anchored by a hybrid PBL programme followed by discipline based clinical clerkships in the final two years of study. The discipline based clerkships include rotations through the major clinical disciplines as well as a series of specialty areas such as trauma, ophthalmology, family medicine and otorhinolaryngology. In MBBCh V, all students rotate through a rural facility about four hours drive from the campus in Johannesburg. The clerkship is coordinated by the School of Public Health and is delivered in a rural health context reflecting the different levels of health care from community health care worker level to the district hospital. The two week block emphasises the care of patients within communities including the development of cultural competencies. In the final year all students rotate through an Integrated Primary Care block. This clerkship, managed by the Centre for Rural Health, is delivered over six weeks in district hospitals and their community health centres in both urban and rural centres across three South African provinces – Gauteng, North West and Mpumalanga. Students are engaged in both clinical work in the district hospital as well as in community based activities through community health centres and are expected to complete a quality improvement project during this time.

The first graduates to emerge from this revised curriculum graduated in 2006.

5.3 Methodology

Data were collected in the latter parts of 2012 and 2013 through focus group discussions with students in the final year of study.

In 2012, final year students were invited to participate in the study through an announcement placed on the electronic notice board of the learning management system for their year of study. The interviews were scheduled for a period following the final integrated examinations and students were able to self select the times suitable for the interviews. Focus group discussions were held over a period of two weeks in November and December 2012. Twenty five students (13% of the class) volunteered to participate in the study and formed four focus groups with between three and ten participants each. These discussions were all held in the central education facility. Males (13) and females (12) were almost equally represented despite the class being made up of mostly females (58%). The graduate entrants made up 28% of the participants compared with a similar proportion in the class (25%). The participants were asked to complete a demographic data sheet which asked if they participated in any extra-curricular activities while studying this degree. Twelve participants engaged in community based work (48%). This group listed work amongst student or church run clinics for underserved urban communities in the inner city of Johannesburg and nongovernmental charity organisations e.g. Children of Fire which works amongst the victims of burns. Half of these participants also listed sport as an extracurricular activity. Only six participants (24%) listed sports as their only extracurricular activity.

A preliminary analysis of the interviews from 2012 was done and formed the basis of the initial comparison process. The volunteer spirit became apparent amongst these participants with strong statements regarding the nature and purpose of social accountability. These participants expressed the concern that there were not many more participants from the class interested in participating in the study. While there were few comments about the individual's freedom to choose the level of commitment to community, there was an overarching drive to repay the debt to the community (inclusive of the education, government and social system) through some measure of service. A clear statement emerged that there were different

kinds of students in the class and these could be distinguished as those *who feel like they are gonna help society and those who feel like they don't need to help society and it's all about where they (personally) are going in life (2012:B:2).*

This strong sentiment which recurred in various discussions led to a particular view of the sampling required. In an attempt to understand the essence of what social accountability means to the student on the threshold of graduation, the second round of sampling became more purposeful with the selection of clinical groups and the invitation being directed more broadly in order to hear the voices of students who had been characterised in the initial set of interviews as being less socially responsive.

The interviews with the student participants of the class of 2013 deepened the understanding of social accountability but the participants' engagement with each other provided insights into a much more contested terrain about what accountability means and the extent to which the individual needs to be altruistic.

The section which follows is a detailed discussion of the findings from the data following open and axial coding.

In 2013,following the analysis of the demographic data as well as the focus group transcripts a theoretical sampling process was embarked on to broaden the reflection on the categories which had emerged from the four discussions held in 2012. Selected clinical groups were invited to participate. These groups had already completed the Integrated Primary Care (IPC) clerkship at the time of invitation in the last three months of the academic year. The IPC clerkship had been identified in the 2012 analysis of the interviews as an important positive influence for the development of social accountability amongst students. The researcher explained the project in detail to a representative from each of the groups. These representatives then assisted in getting the groups together for the focus group discussions.

The clinical groups were used as the basis for sampling in 2013 in a more purposeful sampling than had occurred in 2012. Students in the final year of study choose a colleague to form a pair in which they will work in the various clinical clerkships throughout the academic year. These chosen partnerships are then

placed into larger clinical groups constructed by the academic administration using demographic features such as gender, race and mode of admission into the degree programme.

These student focus group discussions were held between September and December 2013 – the final four months prior to graduation. The discussions were held at locations convenient to participants, either at the hospitals where they were on clinical rotation or in the central education facility which is adjacent to a central teaching hospital.

There were 186 students in the 2013 final year class made up of 59 (32%) males and 127 (68%) females. Seventy (38%) of these students participated in the focus group discussions and this group had a similar gender distribution of males (n=24; 34%) and females (n=46; 66%) to the larger 2013 class. The graduates were overrepresented in the focus groups forming 47% of the group of participants while only making up 32% of the larger class.

In the 2013 group of students, only 24 (34%) listed involvement in community based or student leadership based activity as their extracurricular activity. Of these nine also listed sports. The proportion of students reporting sporting activity as their only extracurricular involvement was 25 (36%). This was higher than the percentage of the group in 2012 (24 %) who had listed sports as their only extracurricular activity. The percentage engaged in community work and student leadership was also lower than that reported in 2012 (48 %).

The average age of the participants in both 2012 and 2013 was 25 years. The average age in each of the groups held in 2012 was between 24 and 27 years of age. The highest average age was in a group of four students as a result of a 38 year old graduate entrant. The average age of the groups in 2013 was between 24 and 26. Two of the 2013 groups, both of which had a majority of graduate entrants, had an average age of 26.

Table 5.1 Demographic description of student participants and classes of 2012 and 2013

	2012	2013
Total Number in class	193	186
Males n (% of class)	81(42)	63(34)
Females n (% of class)	112(58)	123(66)
Graduate entrants n (% of class)	49(25)	60(32)
Study participants n(% of class)	25 (13)	70 (38)
Males n(% of participants)	13(52)	24(34)
Females n(% of participants)	12(48)	46(66)
Graduate Entrants n(% of participants)	7(28)	33(47)
Average age of participants	25	25

The focus group discussions were conducted by the researcher using an interview guide consisting of the following questions:

- What do you understand by social accountability in medical practice?
- Have you seen elements of this included in your training over the years?
- To what extent has this influenced your decisions for the future?
- What are your views of and expectations for your future practice in the medical profession?

The first question was expanded into two parts: students initially expressed themselves from their own experiences and ideas and this was followed by a discussion of the formal definitions of social accountability as described by the WHO (Boelen and Heck, 1995) and THENet (The Training for Health Equity Network, 2011).

The interviews were recorded and transcribed verbatim by a research assistant. These were then edited and reviewed by the researcher. The researcher acted as the member check following the transcription process. Checking for completeness and accuracy was also performed. The interviews from 2012 are labeled A – D, while the interviews from 2013 are labeled from E – L. Open coding was

performed by the researcher and one of the project supervisors independently. These coding books were compared and found to be in agreement. Axial coding allowed the linking of codes to facilitate the identification of categories through which participants expressed themselves. Five categories emerged from these data and in the description of the findings below, extracts from the transcripts of the focus group discussions are used to name the categories. The student group from which the extract is taken is listed in parentheses immediately following the quotation. The process of analysis allowed the insertion of the 2013 data into the categories initially emergent from the 2012 data until data saturation was achieved at the end of the seven focus groups of 2013. There were no discernible differences between how male and female participants expressed themselves in the focus groups and so these have not been specifically identified in the extracts used.

5.4 Findings from the student study

The student expressions in this part of the study are both a reflection of their uncertainty of the meaning of social accountability and their reflective identities which resist the cynicism which they are exposed to in a health system under pressure. As an expression of their conversations five categories have emerged from the initial coding process. Each of these categories was used as the medium through which the theoretical concepts emerged to represent the ideas of the student participants. The categories are represented by direct extracts from student focus groups as follows:

- *It's poorly defined (2012 A)* – balancing expectation and obligation
- *web of interconnected relationships (2012 C)*
- *losing my heart and losing my compassion (2012 A)*
- *more wide angled view of things (2012 C)*
- *If I don't go there, who will go (2012 D)*

The five categories are introduced for context and the content is briefly explained showing the course which the data offers. This is followed by a more detailed discussion and explication supported by the data.

- ***It's poorly defined (2012: A:10)* – balancing expectation and obligation**

The participants engaged with the definition of social accountability from their own experience and understanding of the idea. Their ideas countered the sense of duty with a willingness to serve and the preservation of self with the call to advocacy in the relationship with the community. All of these seemed to be embedded in a notion of delivering a return on the society's investment in their becoming doctors. The challenge of being a completely selfless doctor is felt quite strongly as being in tension with the individual personal needs of the individual practitioner.

- ***web of interconnected relationships (2012: C:4)***

The definition of community occupied many of the groups with a range of ideas of what community means and where it can be experienced. Students reflected on a wide range of definitions of community and how it is made up. The variations in the experiences of community included reflections that students themselves form community, albeit a transient one for the duration of their studies, students nevertheless experienced this community as a place of learning.

- ***losing my heart and losing my compassion (2012: A:1)***

This category explored the development of social accountability through encounters in the curriculum. There was a strong expression that the majority of students arrive at medical school open to expressing the attributes which are central to social accountability. The impact of their clinical role models during their time in the medical school, however, played an important part in the extent to which this openness was nurtured or stifled.

- ***more wide angled view of things (2012: C:4)***

The curriculum offered a variety of planned encounters which might have encouraged the development of social accountability. These were complemented by extracurricular moments of engagement. Both of these experiences contributed to the whole university experience which might impact on whether the graduate becomes or is reinforced as a socially accountable practitioner. Students reflected

on the planned curriculum as providing social engagement opportunities which are often valued only long after the learning occasion has passed.

- ***If I don't go there, then who will go (2012:D:3)***

There were very clear ideas of what the doctor's role is in the encounter with patients which participants perceived to form their social accountability. The doctor's role was often seen in the context of the patient's vulnerability. However, in their expression of where they would choose to work, there seemed to be a varied response to the curricular interventions and to the needs of the communities among whom students have learnt their profession. Similar to results from the literature, the two strongest rallying calls for rural practice were expressed by rural students from both the 2012 and 2013 groups of participants.

5.4.1 *It's poorly defined (2012: A:10)* – balancing expectation and obligation

The participants wrestled with the definition of social accountability and for many the question presented in these groups was the first occasion they had had to talk about the meaning. What emerged very strongly was the idea that social accountability cannot be taught in lecture theatres and students appreciated the opportunity to engage with this research based conversation because *in order to be more effective we definitely need to have discussions like this (2013: J)*. Social accountability was defined through a variety of statements such as this:

> *I mean we are advocating for both patients individually as well as communities and in that sense part of our role is not only to, in short term improve the health of Mr. X who's come with whatever is wrong with him, but it's also within our responsibility to fight for sort of general measures that will improve the state of and quality of life of the community at large (2012: A:5).*

The idea of advocacy was recognised by the participants as being a part of social accountability which was manifested in both their individual relationship with the patient and their relationships within a wider social context.

The notion of advocacy was explored more deeply by the 2013 participants. While students appeared committed to acting on behalf of communities at some level

they had varying ideas of what advocacy might entail from *I believe in being an agent for change in the micro level but I'm not going to go and picket. Well, I used to ….I was in a protest march back in the day when I was still quite idealistic (2013: G: 6).* This was a recurring view of advocacy which contrasted with the characterization of the doctor community as *some of the most passive groups of people ever (2013: F: 5)*. Doctors were perceived as being passive due to their lack of training in advocacy which results in their seeming powerlessness to challenge systems which are ineffective or simply the sense of complacency which participants believed is prevalent.

The complacency is developed while a student. Students become reluctant to challenge the health or social systems which may not work well or the treatment which patients may be getting for fear of being victimized in their assessment or examination process:

> *….so at the moment we're chasing marks*[8]*, and making sure that we pass and that we have to….the problem is why he feels so helpless is because you have to bow down to the system as it is now so that you can get out of medical school at the end of the day (2013:H:7).*

In a response to this assertion:

> *…you would not step up to a consultant and give your opinion, no, you wouldn't do that because it just feels like it's a place where you can't go (2013:H:5).*

And yet there was still the call for increasing advocacy and acknowledgement of *such a difference we could make. Even as interns (2013: J: 5).* This participant also pushed the idea that because she is educated, she had the potential to make a difference in the rural area from which she comes.

Participants suggested that there was a gap in their training - they became aware in subtle ways of their growing importance as medical doctors but this was never tempered by formal reflection on balancing this with their broader roles in society. This was expressed in the views of these two participants describing their

[8] Marks are the equivalent of grade scores in other systems

interactions with curricular moments which directed them to potentially socially accountable practice without calling them to reflect on the deeper meaning of that encounter.

> *...they (teachers in the curriculum) show you what the problem is....like they took us to Diepsloot*[9] *and you could see there was a problem. But they don't equip you with the tools. You know, they don't tell... you don't know what is it that I can do. (2013:K:1)*

> *So, when we do these projects (community site visits), they don't... they don't say stuff like... 'You know, you need to be able to do this stuff because ... what you say... matters.' No-one in the degree ever says that to us. It's something that you pick up in clinical years when people are respecting you as a doctor but no-one ever gives you that foundation that you need to know that your opinion does matter, so you need to be careful about your opinion. Because, I mean, when we did IPC we had to write on a five-star doctor... the doctor as a community leader. But they've never, ever told us we're community leaders. But they expect us to be able to describe how a doctor should be a community leader. It's almost like decorating a Christmas tree just to make it look pretty but you're not actually telling us...(2013:K:4).*

These statements reinforced the idea that students had encountered events which challenged their idea of what it is to be a socially accountable practitioner and yet they had not been given the capacity to act effectively in that situation. The imagery of being a prettily decorated Christmas tree evokes the sense of doing something which looks good but has little impact on behaviour and practice.

It is this social accountability behaviour and practice which evokes the investment analogy. An analogy is developed of the investment process in which the major investor in medical education is judged to be the South African government which provides substantial support for local medical schools. Participants reflected on this idea as follows:

[9] Diepsloot is a sprawling township area of Johannesburg which consists of both formal and informal housing settlements.

(Social accountability)….it's sort of your accountability for society's investment in you. So as you say all the way from teachers to university, everyone trains you, everyone invests in you. So how you are accountable for that. So it's from the Hippocratic Oath to health advocacy to all our, technically our duties that we have to perform. (2012:C:3)

This idea was echoed by another participant in another group:

…do we owe society and community something back? Should we give more? I mean that's just responsibility and I mean just the accountability side, you know everything that we are saying social accountability to me is saying: Why are we doing this? For whom are we doing this? And you know are we accountable to society for our actions and are we putting more into our jobs and going above what we are being remunerated for? Why and for whom are we doing that? Are we accountable to society and therefore need to do that because they are expected to do it – expected by the community (2012: A:5).

The investment idea was carried forward with increased definition of the various parties to whom the return on investment is due and these are listed by participants as being the state who funds the education and training, the academic staff who educate and the patients who become the source of learning during their education and are deserving of a good service while in one's care. In fact, there was an acceptance of the *noblesse oblige* which comes with one's elevation on the doctor *pedestal:*

… by virtue of having the doctor title now, you have a certain amount of responsibility.... like getting born in a royal blood line, you know... there are certain privileges but there are certain obligations as well. And you can't avoid the fact that you have that title. And there's so much impact you... you could do with it. So, I think it would be an injustice actually not to hold yourself accountable to the education that you have received and to the impact that you make, as young as you are. You know, there's so much that has been invested in you and I think it's just... you just need to take a minute and think about what you could do. Just for the title alone.

Because I know, especially in rural areas, that title... they just... they put you on a pedestal and you can make such a difference. So, with all the knowledge we have I feel like we (are) obligated to make a change. (2013:I:5)

The participants' reflections on the definition of social accountability are best summarised in the following:

(as) a medical or practicing clinician one should be fully aware of the social context one practices in and be able to respond to those social needs of patients possibly, and if needs be… one example would be where in hospital there is a lack of resources so one as a clinician one should be able to fulfil the role of advocating for more resources or even advocating for patients. (2012: D:3)

From these comments, the ideas were developed of advocacy service, duty which is often balanced by accountability meaning that the practitioner must take care of him or herself guarding against burnout. The awareness of one's limitations becomes a natural part of the social accountability paradigm.

There was a sense that the community has high expectations of doctors often placing them on a pedestal with the accompanying expectation of certain behaviours both within the professional space as well as in the social environment. Participants suggested that all members of society should have a commitment to being socially accountable but argued that for doctors this is increased because of their encounter with patients in which patients revealed themselves in a unique way. They expressed the desire to balance the expectations of them with their commitment to serving: *I don't think we are obliged to be perfect, I think we are obliged as everybody is, not only doctors, I think we are obliged as humanity, we are all obliged to do our very best (2012: A:4).*

Participants explored the process of exacting social accountability as being both internal and external. There are structures to which one must account and sometimes these were seen as representative of the community or the profession and then there is an internal accountability which emerges from one's own sense of responsibility and the nature of practitioner one hopes to be.

This internal accountability arises from the idea that *all your actions actually end up impacting on someone else's (life) (2012: A:6).* Participants were very conscious of this impact in their individual interaction with patients and the extent to which a positive patient- doctor relationship may have significant positive spin offs for the patient and their uptake of the care which is delivered. They regarded this relationship as forming part of the bare minimum for their practice, but suggested that social accountability may be *"above and beyond"* (2012:A:4) that in order to make a difference in the life of a patient and the community from which they come.

In as much as participants accepted the unique role of the medical practitioner, they issued a challenge that doctors need to move away from the *God complex (2012: A: 5)* which characterises much of the practice which they observed to using the social knowledge which they acquired to the benefit of the community.

This was enhanced in the expression that social accountability is *the duty that medical professionals or doctors specifically have to their immediate surroundings, their community and the society in which they work not just to practice for their own benefit or whatever but also for the empowerment and betterment of their community and society and workplace (2012: A:4).*

When student participants were offered the definition of social accountability from the WHO and THENet during the discussions, it allowed them to ground some of their thoughts with important reflections which were captured to some extent in the preceding comment. Participants accepted that the definitions given by these organisations certainly have relevance for institutions but there were varied discussions on whether these could be easily translated for the individual practice of doctors. The following comment which emerged following reflection on the definitions, illustrates the expectation that some participants had of the university:

> *Particularly just to underscore in South Africa and the history that we come from - the lack of health facilities some communities are exposed to. I think will (it would) be socially negligent if an institution does (did)not conscientise it's trainees to address those needs. Then what is the whole purpose of being a doctor in itself if you don't as an institution… if you*

don't because Wits… Faculty of Heath Sciences is directly placed to influence what kind of doctors we become in the future as well. (2012: D:3)

This idea of the central role which is played by medical schools was echoed by this participant's reflection on the definitions of THENet and WHO:

... for me it's a no brainer... for teaching to be, has to reflect the communities' needs, you can't put doctors out there that don't meet the community's needs (2013:E:2).

Also

I am saying if the (sic) doctors who graduate from here also maybe got some political studies (2013:E:1).

The students believed that there is a responsibility that accrues to the medical schools to engage in teaching that is beyond the biomedical and transcends a systems' understanding of the health care environment. This idea was often couched in terms which reflected the importance of both these large scale interventions in learning as well as the small things one can do which make a difference.

One of the gaps that students perceived in the suggested definitions of social accountability is the absence of a statement regarding the attitudes which such practitioners may have. *Attitude is so important but it's also dependant on the personality (2013: F: 2)* was a recurring expression of the role of the individual. This may be an important addition to these definitions to facilitate translation for individual practice.

Related to this idea of doctors of the future, a participant expressed the idea of the integration of a social consciousness into a general life approach:

I think you know we are also very good at living in silos … we separate our social responsibility from our job, from our friends, from our family. And really it does all need to integrate and it needs to be part of

community ... community can mean anything from one or two people to entire populations you know (2012: A:3).

5.4.2 Web of interconnected relationships (2013: C:4)

Flowing from their reflections on the definition of social accountability, participants explored the notions of community represented by a series of relationships – these relationships within and with the community were often seen as a focus for the students' accountability. They defined community as being *more than just your patients and even more than just your patient's community, the community, the country just as people* (2012:A:2). This statement captured the full range of the participants' views of community which were expressed as ranging in some cases from two or three people to larger communities which may be geographically defined. *Everyone is almost connected to everyone at the end of the day, somehow, so it can be difficult to define* (2013:E:3), represents the struggle of the participants to define a community in both its composition and its extent.

The participants acknowledged the notion of community as extending beyond the patient who presents with an ailment to include the patient as an integral part of a family and a community. Participants reflected on the idea that in a developing context such as South Africa is, the community is much broader than the patients, because those who do present at a health facility are really those who are very sick and in need of attention.

The origins of the definition of community also varied with some participants describing the people themselves as a source for that definition of community. This emerged from their first encounters with work in the community:

I know that you have never seen a place like that in your life you know and you then realize of that community it's not what you think a community is, it's what they tell you a community is. You can't get that from teaching, you have to be there and you have to see it and people have to come to you with that information (2012: A:4).

Practitioners must accept that their actions have impact beyond the single individual patient consultation despite this being an important point of impact.

While many participants regarded the public health sector as their primary community, there was an acknowledgement that those who are able to afford private health care must also be regarded as community. There was a perception that the curriculum does not engage the private health domain sufficiently and that this leads to misconceptions:

> *To me it felt like throughout the degree that we've done there's a general opinion amongst medical people and people from outside that you are only serving the community if you are working in the public sector but if you want to go to private that you're actually not serving the community. I have a problem with that viewpoint because I think (that in) the whole country…..sick people are sick people…they are the community we are serving. Whether you are serving in the public or private sector, the way in which you conduct yourself as a doctor and in a professional capacity is your social accountability. (2013:J:GG)*

The concept of community that many students had was often formed by their experiences within the curriculum. Some participants expressed the view that their backgrounds, particularly from a private schooling, may have limited their view of what community was.

Part of the conversation addressed the vulnerability of communities in their relationships with the health system:

> *In South Africa and Africa we are dealing with people who are disempowered economically, disempowered educationally as well. So it forms part of the vulnerability that number 4 was talking about that these people do not have or are not fully aware of the recourse they can take if they've been wronged (2012:D:3).*

An essential part of a socially accountable response becomes the idea of *empowering and educating them (the community) in (2012:A:2)* regard to the actions they need to take for improved health.

New codes emerged from the discussions regarding community with the 2013 groups, namely, the student community and the medical hierarchy.

The student community was seen as a space for socially accountable action as well as the place of learning through the experiences of others what community meant.

> *I feel like social accountability, with us as medical students, needs to start way **before** our clinical years. If you live in residence, what are you doing within that society, or that community? If you are at medical school and they're doing like a (charity) drive for kids in the hospital ….. that's a form if social accountability. I think wherever you are and at that period of time, your responsibility is to the community that you are in (2013:I:6).*

The participants, many of whom had similar ideas of students as community, acknowledged that the lack of time in their training reduced the ability to build the extracurricular relationships which foster good community either amongst students or beyond in broader communities.

During the allocation of students for group work in the curriculum there is a combination of students' self selection of pairs which are then combined by the academic administration into larger groups, mindful of the *desirable* demographic distribution. The student participants acknowledged the benefit of this administrative intervention as contributing towards the building of understanding amongst students who may come from different backgrounds. The apparent benefit of these constructed groups was captured in the following dialogues from two different groups:

> *I think for me it helped a lot because we had a brilliant group (selected by faculty). We even chose to stay together as well, and we met different people along the way. For me, it was helpful because honestly, if I had to choose my group, I wouldn't have chosen this group. But after working with them for a while, you realise the benefit. It's important because in our country...unfortunately, the race... the background that you come from... it's an important thing (2013:I:6).*

> *I would agree with that (the faculty structured groups). Because I would never... if I had to pick a group... there (were) some people that I was paired with for PBL group... for community project. Yes, I would never*

have chosen that person and said "Come let's go." I didn't know him from a bar of soap. It's kind of like how it works... and I mean, I learned to appreciate certain things that I had because the person next to me in my PBL group... I was complaining about something that was putting pressure on me in my studies but when I heard what was putting pressure on them for their studies, it made me wake up and think 'Gee, just be grateful'. And I think I had some situations when I was in the dumps ... and some other person learned a lot from that. I just think you learn a lot off (from) your peers (2013:J:5).

There was an important role for the student collective in both learning from and teaching each other, but also for development of a sense of community amongst themselves. It was this sense of community which many participants viewed as critical to the development of a social conscience.

The hierarchy in the medical profession was cast as an important aspect of the community which the participants saw themselves as entering on graduation. This hierarchy appeared to have two faces.

A more positive expression of this hierarchy referred to an important learning paradigm reminiscent of the ancient learning systems for medicine:

I actually appreciate the whole hierarchy system, you can also call it the old apprenticeship system I think it's really a valuable system in medicine (2013:L:5).

The value perceived by this participant was the ability of any medical practitioner or student to assist those who are progressively below them in the hierarchy in their learning – a consultant teaches a registrar in the same way as a sixth year student can teach a fifth year student. This has resonance with the theory of communities of practice and their observed benefits for professionals' learning (Berry, 2011). The sense of knowing one's place in the hierarchy may have a positive effect.

The antithesis of this is that these same participants were uncertain of what their response would be to the more junior member of the group reflecting to them

about their inappropriate conduct in the work environment. The idea of knowing one's place becomes a negative factor in the limitation of that student's expression either in terms of advocacy on behalf of patients or in the observation of inappropriate conduct. In a conversation in one of the groups it was represented in the following extracts:

> *I think all of us here at med school - we are empowered people. I think we know that we are especially with the support of our families but then again the lessons of life you learn here at the hospital, sometimes, you really have to keep quiet for your own sake, for your career's sake because in real life when you are dealing with certain types of people and you kind of come up with your voice is important and you have rights you'll definitely be crushed. So it's one of the lessons that you learn in life (2013: L: 2).*

> *We keep mentioning this whole relationship and the fact that there's a hierarchy and discerning your role and discerning where you fit in this hierarchy and recently I've been watching it, I've been watching this hierarchy more intensely and almost with a more disappointed heart that I allowed myself to slip into that role that I felt I needed to play for everything to run smoothly. You know don't speak up too loud or whatever. And like I said I've actually been quite disappointed in myself 'cause you really watch how each person tries to speak in a way that presents themselves a bit more importantly than the person who's a bit lower than them. You know, you really get this sense of everyone's egos basically. It's just a boxing match of egos. (2013:L:4)*

Two negative consequences of the hierarchy were that the students lose their voice especially if that voice is seen to challenge the prevailing status quo. They also sacrificed their opinion in order to fit into the systematic hierarchy. Both these ideas may adversely affect their learning of the role of advocacy and their ability to articulate in clear voice the needs of their patients. Their fitting in is seen as crucial because this has impact on their assessment processes during their student years as well as in their internship learning period. The power differential between the teachers and the students meant that students often compromise in order to keep

the peace. In many ways this is linked to the hardening of their attitudes as their learning progresses.

5.4.3 *Losing my heart and losing my compassion (2012:A:1)*

Student participants echoed the community's notion of expecting love in the doctor – patient interaction. The degree to which love may be expressed in the relationship depends on the personality of the doctor. This category is headed by a quotation which emerged from a student's reflection on the changes he had experienced over the course of his training. It arose from an exploration of what makes an individual more likely to be socially accountable and the researcher's exploration of this idea through three questions about how one ensures social accountability in a practitioner – does the student arrive at medical school with social accountability, does the curriculum engender this or is it an accident of a post graduation professional encounter?

There was a strong feeling amongst the participants that *99 percent of you as a person with regards to morals and ethics and how you live your life is formed before you get to medical school (2012:C:1).* Morals and ethics were expressed as an integral feature of a socially accountable practitioner*. You come with a certain, you know, a trajectory and you tend to stay on that (2012:C:4)* was a widely held view of participants.

However, there was an acknowledgement of the role of the medical school experience in helping to moderate the experiences from before that. There was a sense that certain experiences may modify or develop the *premorbid personality (2012:C:3).*

There was a recurring theme of desensitization over the course of their medical education. Part of this desensitization towards social accountability was influenced by the focus on assessments. Some of the participants reported that it needed a specific moment of reflection to arrest this decline into a cynical attitude towards patients and their care:

> *And at the beginning of this year doing paediatrics, I suddenly… I had a moment of revelation where I… I've been so scared that I had lost my*

heart and I've watched myself become desensitized and cynical over the years……and I found out that I hadn't lost my heart (2012:A:1).

The 2013 group of participants expressed their cynicism far more strongly than those in 2012, accepting this development as a result of their six years of study. This cynicism was linked to the arrogance that students had experienced amongst their teachers and their peers. An interesting feature was the reflection that the hardship endured through their studies entitled them to a certain arrogance but *not too arrogant* (2013:H:11). The development of this arrogance was, in part blamed on the encounters through their training:

… you become arrogant because people allow you to be arrogant and also because people have such high standards of you that you actually think that you're the best person and you're powerful and that you can heal people" (2013:H:11).

The balance between allowing the system to *beat any compassion out of you after a while (2013:H:7)* and being drawn into a cynicism and arrogance was a real battle for students. The expectation that, somehow, as a medical student *you must be so used to people dying that it doesn't affect you anymore (2013:H:9)* adversely affected the students' ability to remain compassionate.

Many students reported the importance of reflecting on where they were in terms of their own personal and professional development. Some spoke of their need to harden their approach in the face of the level of suffering they had to witness. For many this was seen as a self preservation strategy. The levels of suffering which students encountered as a result of inadequate resources took its toll and created negative perceptions for the students:

I think practicing medicine in South Africa tarnishes you negatively, I think that we are less humanitarian probably than we should be when we finish medical school, just because we see so much suffering, we are so used to it (2012:C:1).

This idea of reflection enabling an arrest of the encircling cynicism and arrogance was reflected in the following:

Now I mean I know you need to be firm with trauma patients, most of them are very drunk and they aren't exactly the most nice(sic) people... I just took a step back at some point because I remember trying to reason with this one person and I was just actually being ... actually shouting at them and I just realised that... now I am talking like this consultant who I really don't like. Now I am being this person and just thought: No, No, hang on! Something's got to change. You should, I guess, just have that reflection for yourself and .... I am happy to credit it for myself... because that is what I did. (2013:E:3)

There was a strong recognition that there were moments of reflection which may have been crucial in determining what direction a particular encounter with either the health system, a teacher or, in fact, a difficult patient may have taken the student. Often that reflection allowed a positive correction of a potentially damaging experience. One of the participants expressed a widely held need for structured places of reflection in the curriculum which are less driven by enforced submissions and assessments:

I think that there should be some sort of guidance like a periodic thing when you meet every so often for guidance… because otherwise you just want to do it (formal reflection assignments) and get it out of the way… you don't… half of the time you don't even think about what you're doing (2013:F:6).

These reflective spaces would allow students to reflect on their own vulnerability:

I was talking to this other doctor, and I was telling her about how nervous I was about next year and she's like 'You know, one thing you have to learn as an intern, is to forgive yourself.' And she said 'You need to learn that you are called to save lives, not to prevent death. If the person tells you that "x", especially in gynaecology, someone would tell you that 'I was raped.' And if you take time to think about what that means you won't... I don't think you will cope emotionally... you will immerse yourself too much. It will be great bio-psycho-social... I think that's what it's all about...

but theoretically we need to protect ourselves for the sake of the next patient, as well. (2013:I:5)

There is a sense that this type of guided reflection may prevent the *compassion fatigue (2013:E:5)* which characterised the students' progression through medical school.

5.4.4 More wide angled view of things (2012:C:4)

Despite the perspective which participants had that their personalities are formed in large part prior to their entering the medical school environment, there was an appreciation that the curriculum offered opportunities to broaden the vision that students and then subsequently professionals have – the wide angle view of things.

There were differing views on which activities deepened their sense of social accountability but the prevailing view was that the community site visits in years three and four and the Integrated Primary Care clerkship in final year – both learning innovations based outside of the central teaching hospitals contributed to this broader view of health systems and the community. The Community Site visits and the Integrated Primary Care clerkship were introduced into the revised curriculum in 2003 and 2006 respectively.

Both of these encounters are activities delivered in communities which may be regarded as underserved in terms of the definition of social accountability offered by THENet (The Training for Health Equity Network, 2011). The impact that these have had on students reflects that in a South African environment, these interventions provided an education of the social milieu from which the patients have come in order to be seen by students. The community site visits were able to develop students' views of situations in which communities find themselves:

The community service (community oriented primary care) projects that we did in groups of 3 or 4 where we had to identify a problem within our (own) community and try and fix that. I think that gave me a bit of a perspective of what as an individual we(I) could potentially achieve. (2012:D:5)

The exposure to alternate spaces to their upbringing has had a positive effect:

> *I think I've been quite lucky I mean a lot of us have had these experiences going into rural South Africa you know, but a lot of us have also had the chance to go into urban South Africa. And most of us come from nice little suburbs and we have a wall and fences and all that. So as much as we sit in a hospital and we see the patients that come in and we see them in our own environment, the chances that I've had to go into Hillbrow and Alex(andra), into Braam(fontein)*[10] *and into those areas to see where my patients are coming from makes… has made me far more aware of what I can say to them and whether what's actually realistic for me to say to them (2012: A:5).*

Cultural safety was a challenge for students who argued that *we don't really touch on certain nuances and certain new cultures which may influence how we actually give health care (2013: E: 3).*

This sense of being given the ability to look at things differently and getting a sense of the influence an individual may have pervaded many of the discussions. The IPC rotation was credited with teaching a broader perspective of the health system:

> *And I must say that IPC has to be one of the greatest learning experiences and just in general as to how South Africa as a health care system runs (2012:D:8).*

Participants reflected on their experiences on a day to day basis at the patients' bedsides which allowed them to enter the world of the patient and understand that at their level of vulnerability, a very small humane gesture may have a profound impact on the patient's experience of their encounter with the health care system.

It was also at the bedside where student participants had their most abrasive encounters with inappropriate conduct. The overwhelming experience of

[10] Hillbrow is an inner city community in Johannesburg where there has been considerable social decay over the years. Braamfontein is the site for a church based health programme which serves homeless people, mainly of foreign origin. Alexandra is a township area approximately 15km from the Johannesburg CBD.

participants was of role models who they hoped not to emulate in their own practice. The participants experienced a disjuncture between the lectured ideal and the lived experience of encountering their clinical teachers leading them to say:

> *You can have a million lectures on how to be a good doctor and what's ethical and what's not ethical and (it's) one hundred percent about what you see when you go into the wards (2012:C:1).*

The lived example had the greatest impact of what altered students' perspectives of care for patients.

> *And there are definitely also some good role models that we'd like to emulate – who actually teach us with patient care standards as well. Not only in terms of the quality of care patients receive or evidence based medicine but also in terms of how one talks to patients as well. That soft tone, that posture you adopt to a patient as well. (2012:D:3)*

The paucity of ideal role models was carried through the discussions in both 2012 and 2013:

> *I don't think enough of them have shown us how to be good to your patients and actually come down to a level where we don't feel like you are a much more powerful figure than the patient. I don't think that enough of them have shown us that. It's not enough to be lectured on it. All the "heads", I don't (know) if they get it too, but they need to have that awareness, they need to be enforcing it in their teams so that when we're learning we would be learning something that's actually in practise (2013:E:2).*

Students offered insights into the pressure of going through the *meat grinder* (2013:G:6) that is the medical school administrative process which they claimed was *saying you must be accountable, they're teaching you, but they're not practising it (2013:H:4).* This kind of contradiction was also encountered in the clinical academic space with the assertion that *we're theoretically trained in the*

bio-psycho-social practice but if you give us a patient the only thing we know how to correct is the biological problem (2013:G:4).

5.4.5 If I don't go there, then who will go (2012:D:3)

THENet's evaluation framework places great value on the difference a medical school makes to the health of the people it is mandated to serve through the monitoring of where the graduates work at the end of their training (The Training for Health Equity Network, 2011). The participants in this study offered varied reflections of where they would finally practice medicine describing the changes that had occurred in their choices through their encounters with the medical curriculum as well as confirming ambitions they held when they entered the medical school.

In a very bold exchange in this regard, a student of rural origin made the statement that

> *I think our training.... has only confirmed my decision in terms of where I'm working this year. I come from a rural area and in fact I did my elective as well in the local district hospital there.(2012:D:3)*

The above comment demonstrates a stated commitment from a student who entered the curriculum from a rural area and was open to the rural engagements in the curriculum, but in the following quotation he reflected on the tension which appeared to exist in the class with regard to choosing a remote site for internship. The comment refers to the moment at which the allocations for the internship period were announced in the class:

> *...my friends were there and they were laughing at me: You're going to such a place, my goodness! You are going to the bundus*[11]*! You are going to what?? I said to most of them, if I don't go there who will go there? (2012: D:3)*

[11] Bundus is a South African term which describes rural areas. A word which emphasises the remoteness of the place under discussion.

The student who chooses a rural area for placement is quite sharply derided and may reflect the divide within the class regarding the choices made. Despite this there seemed to be a commitment from those students of rural origin to return:

> *I plan to go and change things. You know, I plan to get my degree here, I'm going to go back home. It's in Limpopo*[12]*. Because I did my elective there's a lot of things that I'm going to .... go back home and try and fix it (2013:K:1).*

The same participant reflected on his capacity to effect the change he seeks commenting:

> *You know I feel like I will get there and I will have some sort of idea of what to do but implementing it will be a bit of a problem. I don't feel I am prepared for that (2013:K:1).*

Despite the feeling that the preparation in the curriculum may be inadequate for work in remote areas, for many students, their encounter with the curriculum was a moment of reflection on the path which they may follow:

> *I always wanted to travel about, so my dream was to sort of qualify and travel around the world. But I think, actually I started doing medicine because I wanted to work for MSF (Medecins Sans Frontieres) but I think I've learnt the need, like there's always a need where you are based and you can probably do more work in the community you are from. I think I've learnt like it might be sort of glamorous to go and work where the latest volcano just hit but you probably do more as you say, go to rural Limpopo*[4] *for a couple of years and you are getting a huge amount of experience from there as well. So I think I've learnt that: Yeah there's a huge need right where we are basically. (2012:A:6)*

The change of heart about what was a priority appeared to be one of the impacts of the curriculum which this student reinforced:

[12] Limpopo is the northernmost province of South Africa with large rural environments.

…the heart is still there and I know I'll never be able to look away from that. The thing that drives me is community upliftment. And everything I do, everyone I see, they (referring to fellow students) all know that will be my driving force. It's pretty much stayed the same just reinforced the recognition that there is a dire need out there. You just realize how much more as you train further along the line how much more you can contribute to addressing that need (2012:A: 1).

Participants wrestled with whether the practice of social accountability was limited to generalist practice. In the South African context, family medicine has only recently been registered as a specialist discipline. If one does not specialize in this context, one essentially chooses general practice either in private practice or as a hospital based medical officer. With most clinical training occurring in the tertiary hospital setting, students reported that there was often a negative attitude to general practice which was expressed by the consultants who taught at the bedside of these hospitals. There was a general acceptance that the encounters in the curriculum had influence on both spheres of possible practice:

I'm personally inclined to become a specialist or a sub-specialist but what I've enjoyed about all the social aspects that I've seen is that it really allows me to get to the broader perspective so that I can incorporate that and make that a specialty or sub-specialty much more inclusive not just the ten patients that you see in and out. (2012:A:4)

The apparent limited numbers of patients seen within specialist practice represented a challenge for the group discussions. Specialist practice was often placed in contrast to practice at primary care level.

Students appreciated the extent to which the curricular experiences in the primary care settings had a positive impact on their growth:

I was at Alex Clinic[13] *for IPC. Prior to IPC I would have never thought I would go to a clinic. I thought that I would do my comm. serve*[14] *at Bara*[15]*,*

[13] Alex Clinic is a Community Health Centre in the township of Alexandra. It is an urban township about 15km from the campus of the Faculty of Health Sciences. This community area was the site of the Urban 3 interview in the community section of this study.

I thought I would be at an academic hospital for comm. serve but after being at Alex Clinic, and we were never rushed to do a consult even if it was just those chronic people all we had to do was just re-write the script. We sat with them, we talked with them, it was just a less stressful environment. You had that time with your patient, you didn't feel rushed and I mean I actually considered it's not a bad thing to go into primary health. ….you are torn between what your personal fulfillment and also you want the maximum amount of people to benefit (2012:B:3).

There was a strong desire to serve the greatest number of people which emerged from the participants and this linked to some extent to the definitions of social accountability. The definition of social accountability from THENet includes the often underserved communities as a focus (The Training for Health Equity Network, 2011) which generated debate amongst the participants who agreed that people who required an accountable approach to their health care may come from all levels of the social gradient. Despite this, there remained a recurring commitment to the community development in whatever context practice would happen. In capturing the participants' views in relation to community and the doctor's responsibility one participant stated:

So that they (the community) can empower themselves to just change their own life in a realistic way you know. If each of us are empowered in our own life in a unique way there'll be no need to figure out the greater good because I think there's a saying that if you take care of the pennies, the pounds will take care of themselves. The greater good will just come of itself if you just take care of a small little thing. (2012:A:9)

Flowing from this idea of the doctor as an active agent in the society, student participants expressed a broad view of the role of the doctor in this regard. There was an appreciation of the great expectations which communities had of the individual practitioner and accepted that this came from the fact that they(the

[14] Comm serve is a colloquial reference to the year of community service medical officer time which is expected from each medical graduate before they are able to register for independent practice in South Africa

[15] Bara is an abbreviated reference to one of the major central teaching hospitals in the academic complex. Full name is the Chris Hani Baragwanath Hospital in Soweto

community) *come from a much more vulnerable position when they come to us (2012:A:5).* This vulnerability is what separated the expectation society has of doctors from the expectations held of other professions, for example, law.

There was an overall concern about the commodotisation of the health interaction which partcipants felt characterised the practice of private health in South Africa. While some participants felt that private practice needed to be run as a business because it represented the livelihoods of many practitioners, the predominat view was that this should not be the case because of the vulnerability of the patients who may seek assistance:

> *…. being different from any other business, I mean it's people's health, people will pay anything, you know, to keep their health or to save their life. I mean if you're buying cars you can choose whether to buy a Volksie*[16] *or a Ferrari but if it's your health you'll pay anything, you'll bankrupt yourself. It is different to other businesses because of people's vulnerability (2012:C:4).*

Participants repeatedly reflected on the contribution which the power differential in the relationship between doctor and patient makes to the sense of vulnerability which patients experience in the dyad:

> *….. there is a bigger gap in power between a doctor and patient than there is in anything else, you know that, I think, is very true. I think that was what X was getting to earlier, that the gap between the two and the power imbalance between the two is wider in medicine than in any other field, I think that's why we need to be more morally restrictive of ourselves (2012:C:1).*

The comment reinforces the idea that social accountability is a manifestation of the values base of morality and professionalism.

[16] Volksie is a South African term for the Volkswagen. In this context probably referring to the original Volkswagen beetle.

5.5 Emerging theoretical concepts

The five categories which emerged in this data offer a reflection on the essential attributes of a socially accountable medical graduate. These categories are connected through three significant domains: reflective practice (balancing expectations and obligation*; losing my heart and losing my compassion*), relationships (*web of interconnected relationships*) and understanding complexity (*more wide angled view of things*; *if I don't go there, then who will go*). The emergence of the socially accountable graduate from training into practice is subject to the constant tension between catalysts and detractors in each of these domains. The catalysts assist in demonstrating to the student *how we practice to serve the community in the best way possible (2013:L:2)* in a spirit which is never used up completely. Detractors in that learning journey, on the other hand, limit the active engagement with the challenges of practice because *it feels like it's a place where you can't go (2013:H:5).*

5.5.1 Reflective practice

The ability to stop and think about the progressive cynicism to which students become vulnerable over their training allows them to redirect their development and to retain some of the idealism with which they entered the medical school. There has been growing acknowledgement of the importance of reflection in the development of a professional in order to enhance their ongoing practice (Schön, 1987; Mann et al., 2009; Mullan et al., 2014). The need to establish nurturing education spaces is an important positive factor in the development of a reflective practitioner while the tendency of strategic reflection becomes a self serving practice in the interest of higher assessment scores. In order to build these educating spaces where reflection flourishes, the communities of practice which are part of the clinical practice domain need to acknowledge the entry of a novice clinician so that their entry is legitimized (Berry, 2011). When the role of the students is acknowledged and strengthened, the teaching clinician can provide guidance for the process of reflection which is closely aligned to the experience. The closer the mentor is to the student in reflection, the more likely they are to harness its full benefit.

On the other hand, strategic reflection refers to the students' ability to write for the assessment of the reflective assignment. If the curriculum inserts reflective tasks in a manner that emphasises the mark which is attached to the process then the students appear to reflect with that assessment in mind. This is often further encouraged if the task is not aligned with the daily practice of the student or with a teacher who may have been part of a particular experience that is the subject of the reflection.

Figure 5.1 below shows the tensions which exists between the forces which act as catalysts in the promotion of reflective practice supported through nurturing education communities and those factors which force strategic reflection and so undermine reflective practice.

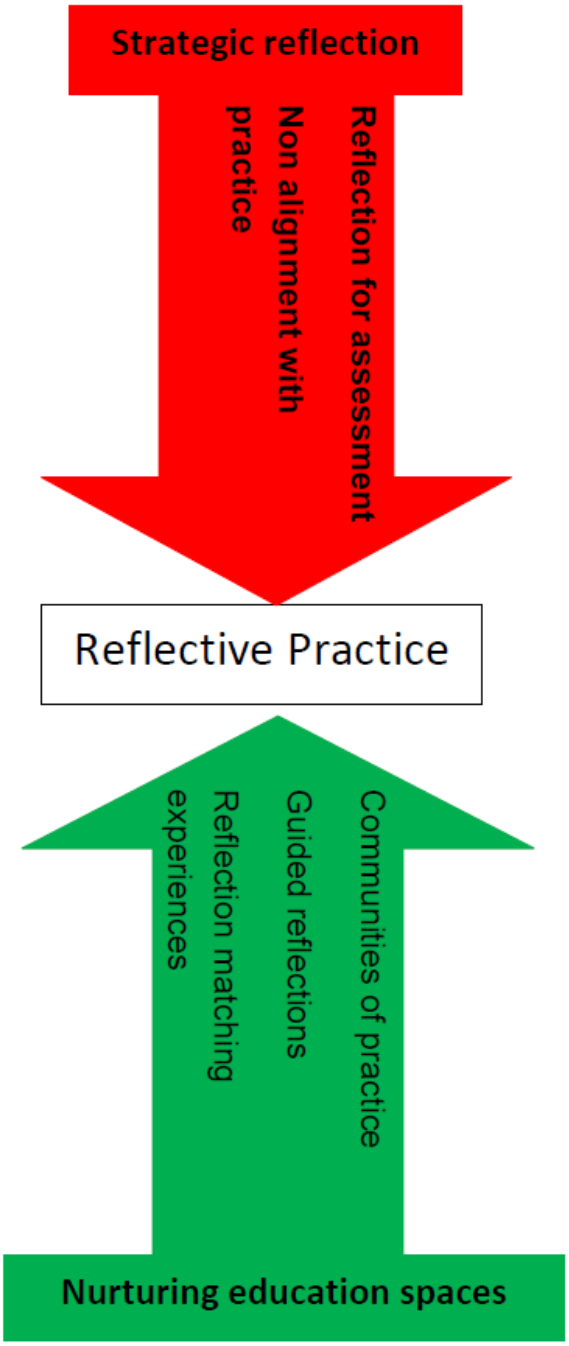


Figure 5.1: Factors which impact on the development of reflective practice

5.5.2 Understanding Complexity

One of the participants in this study suggests that the curriculum offers the chance for a *more wide angled view of things (2012: C:4).* It is perhaps this broadened perspective which leads to the understanding that every action has an impact on the lives of other people and none more so than in the actions taken in relation to

a patient and the illness which they bring to the doctor. Understanding that even a small action may have an unexpected larger consequence is central to developing the capacity of a graduating professional to understand the complexity of the health system. At the opposite end of the spectrum, one of the participants reflects that *we are also very good at living in silos (2012: A:3).*

All actions impact lives. This concept of impact is given greater impetus through the students' reflections that they were most likely to learn about communities and their way of life directly from them when they were immersed amongst the community for learning. The fact that students had encounters with communities in multiple different community based environments from service learning events to clinical learning in remote sites added to their understanding of health care as perceived by communities and as delivered through the different levels of care. Taking students out of the hospital context becomes an important experience. In these varied contexts, the imperative for teachers to address the social needs of these communities engenders the spirit of responsivity amongst the students. The combination of multiple community based teaching environments and teaching which matches the social context enhances the development of advocacy amongst the students. The nurturing of the advocate implies the broadening of the student responsibility both for the individual patient as well as for the community which surrounds them.

The understanding of complexity demands a curriculum which is at once diverse and is agile to be able to adapt to different students and the various learning environments which they may encounter.

In direct contrast to and detracting from this ideal is the culture of learning and living in silos. One loses the connection between the disease and the patient who experiences illness and between the student and the society in which they learn. Students expressed that this often results in their intense focus on assessments which are often not linked to the common health priorities of the communities in which they learn. Linked to this is their limited exposure to positive role models who show them how to be good: *that soft tone, that posture you adopt to a patient as well (2012:D:3).*

5.5.3 Relationships

Suchman (2006:S40) opens his article on the importance of relationship-centred care with the following:

> *Relationship-centred care is a clinical philosophy that stresses partnership, careful attention to relational process, shared decision-making, and self awareness.*

This statement helps us place relationship centredness at the heart of our educational endeavours in the health sciences. The domain of relationships is characterised by the tension between, on the one hand, ensuring compassionate encounters while, on the other, working to reduce the impact of inequality and the power differential on the relationships in which we are engaged (See Figure 5.2).

Compassionate encounters need to be developed at three levels:

- Entering the world of the patient

This world of the patient is experienced at the level of the individual seeking health care and in the dynamics of the society which surrounds them. This is best captured in an extract referred to earlier:

> *I mean we are advocating for both patients individually as well as communities and in that sense part of our role is not only to, in short term improve the health of Mr. X who's come with whatever is wrong with him, but it's also within our responsibility to fight for sort of general measures that will improve the state of and quality of life of the community at large (2012: A:5).*

The emerging ideas from the students are that the community of patients teaches them a great deal.

- Building educational intimacy

This learning must be matched and furthered by teachers who reflect the ideas of partnership and shared decision making with their students (Suchman, 2006). In building a professional level of intimacy with students, teachers have the added

responsibility of creating an environment which encourages the student to become more self aware (Suchman, 2006).

- Keeping one's heart

The desensitization which has been noted by many participants can only be arrested by an increase in the student capacity to become for self aware. The reflection by a participant that he still had not lost his heart came from a moment of encounter with himself and a recalibration towards compassion.

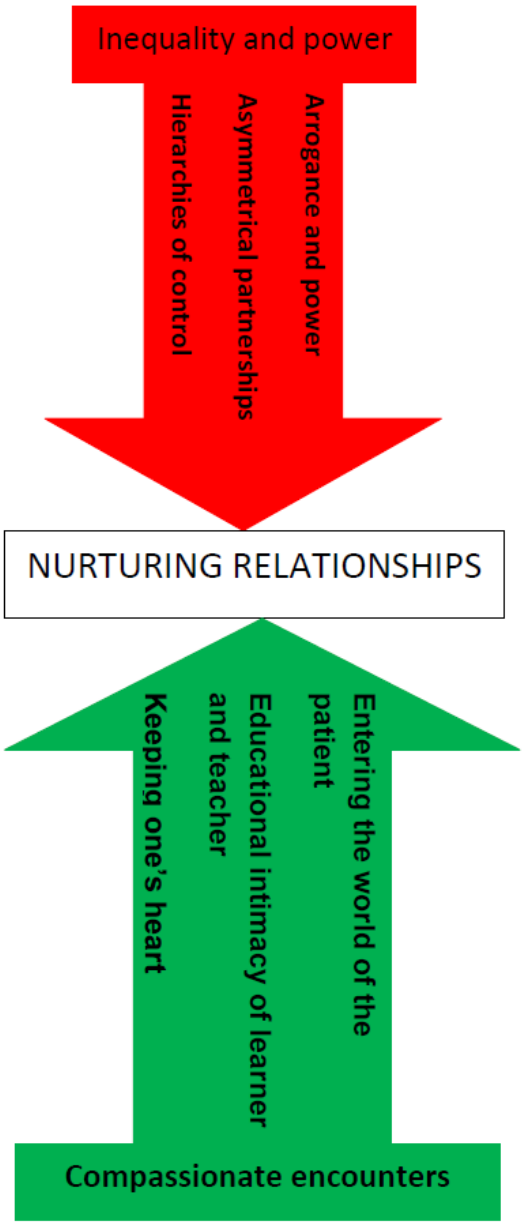


Figure 5.2: Factors which impact on the building of nurturing relationships

These three actions acknowledge that the asymmetries of power which emerge in an unequal society and contribute to the social gradients which contribute to ill health (CSDH, 2008; The Marmot Review, 2010). This is an abiding feature of the South African health system where the asymmetries are experienced in the areas of social status as well as levels of education. These experiences are further compounded by the professional power afforded to doctors and the accompanying arrogance: *"you become arrogant because people allow you to be arrogant and also because people have such high standards of you that you actually think that you're the best person and you're powerful and that you can heal people" (2013:H:11).*

In the education space, this arrogance is played out in the hidden curriculum which students encounter and the sense that they are in a constant battle with those who are senior to them. The tension between student empowerment and their disempowerment is almost palpable in the following extract: W*e are empowered people. .... you learn here at the hospital, sometimes, you really have to keep quiet for your own sake, for your career's sake ... your voice is important and you have rights (but if you use them) you'll definitely be crushed. So it's one of the lessons that you learn in life. (2013:L:2).*

The convergence of reflective practice, relationships and understanding complexity which create an environment which supports the development of social accountability are represented in Figure 5.3.

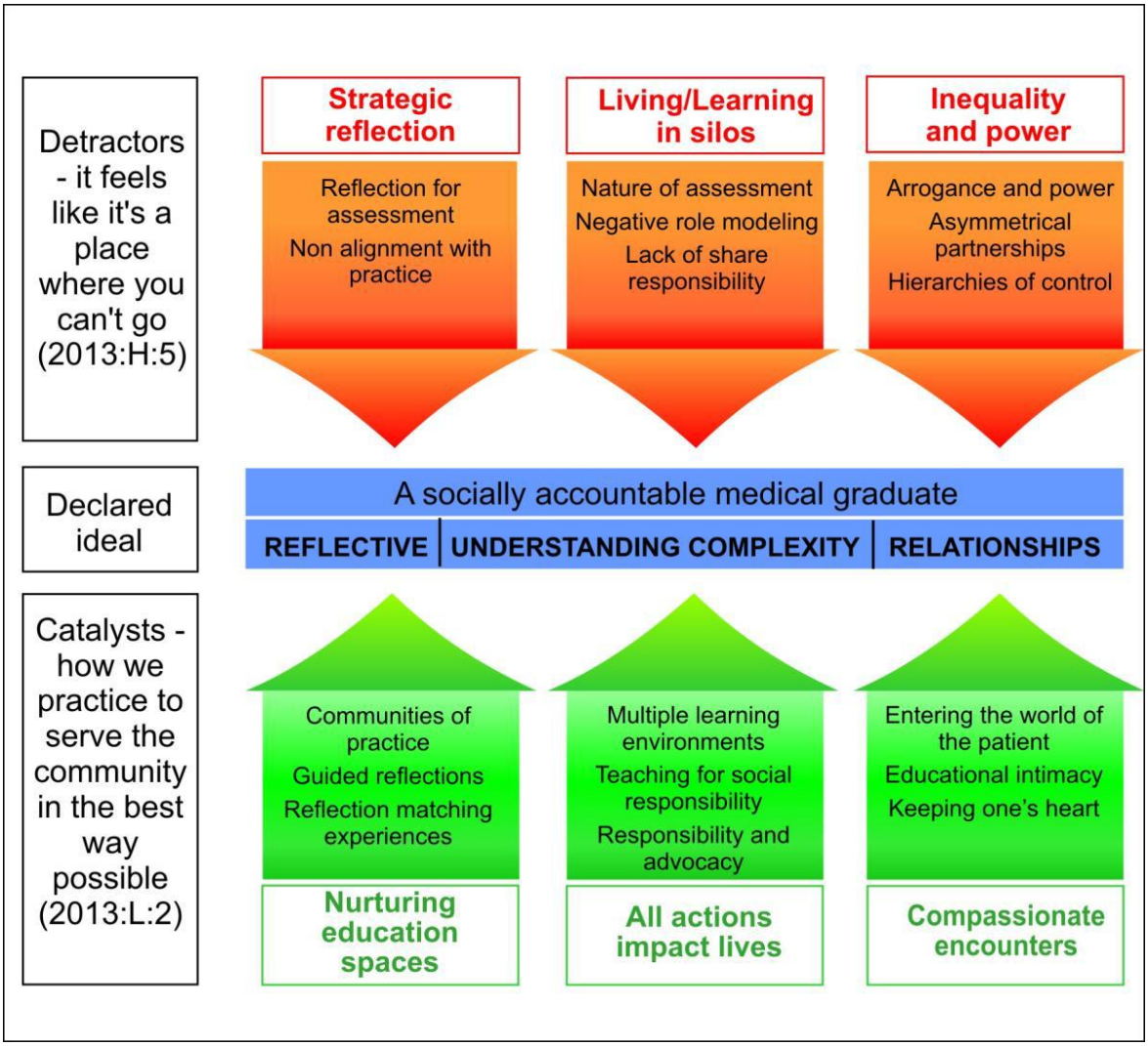


Figure 5.3: The tensions between catalysts and detractors in the education of a socially accountable medical graduate

5.6 Conclusion

This chapter has described the vision of student participants in this study. They are reflected in categories which relate to the great obligations and expectations society has of it doctors and the interconnectedness which characterises the communities which make up this society. The students reflected on the curriculum as giving them a broader perspective on the more social determinants of health and yet were challenged by the erosion of their sense of compassion through their training. The expression by rural students of their desire to return to their communities to serve in their professional work resonates with the literature (The Training for Health Equity Network, 2011)

The chapter concludes with an explanation of the theoretical connections between the various categories which were represented in graphic form (See Figure 5.3).

The next chapter will discuss the conduct and the findings of the third part of this study in which the education partners were engaged.

6 Conversations with partners in medical education

6.1 Introduction

The community concept of social accountability as a dimension of ubuntu (African humanism) has been presented earlier in this thesis. These concepts emerged with a focus on a community of reciprocal relationships at the heart of which is a caring and loving relationship between the individual patients and their doctors. This community of relationships is nested within a series of layers representing the national context in which ubuntu becomes the aspiration. The ubuntu framework which aspires towards relationships which nurture was developed further in the previous chapter in which final year students described their expectations for an ideal graduate. In characterising these relationships as part of learning communities of practice, the students have called for the development of teachers who are attuned in their practice to appropriate role modeling. It is these teachers which form the central agents in this chapter. They represent the academic partners in the education of doctors together with the provincial officials and local government managers who are also interested parties in the education of the medical graduate.

This chapter allows the widening of the perspective on what social accountability is perceived to be and, more importantly, the aspirations of these partners in their efforts to train these graduates appropriately. This chapter adds a third dimension to a growing definition of social accountability within this study.

6.2 Methodology

The study was conducted amongst people associated with the MBBCh curriculum at Wits University. Partners were identified as consisting of academics who are

involved in teaching medical students either in the hospital or laboratory based clinical disciplines. Two initial key participants were purposively sampled for their knowledge of and participation in current thinking in the faculty regarding social accountability. A snowballing technique allowed expansion of the participants until data saturation was achieved and the various disciplinary spaces amongst the academic staff had been engaged. Twelve in- depth interviews were conducted. Those interviewed practiced as specialists in internal medicine (two participants), surgery (three participants, one of whom was predominantly an administrator), paediatrics (one participant), family medicine (two participants), pathologist (one participant), public health (two participants) and psychiatry (one participant). Three of these participants were women.

These participants were complemented by three individuals who were part of the management of health either at provincial or local government level. These three participants were selected purposively to reflect the levels of government which provide clinical platforms for the education of doctors. As a result a regional director and a clinical executive from the North West province as well as a manager from the City of Johannesburg were interviewed. A director at a leading health care insurance funder was identified as a key informant and was interviewed.

All of these participants gave informed consent to participate in an in - depth interview, each of which was conducted at the convenience of the participants at venues of their choice. Confidentiality was assured and the conversations were recorded and transcribed verbatim. The interviews took between one and two hours each.

The interviews for the academic and provincial partners were conducted contemporaneously and thematic analysis was applied with constant comparison with each consecutive interview. The initial transcriptions were subjected to open coding by the researcher and one of the study supervisors. Axial coding allowed the convergence of the data into categories for the development of theoretical concepts.

The extracts from the interviews are labeled as follows: Acad 1 would represent an academic who was interviewed earliest in the research process, Part 1 would be the first provincial official interviewed and Key 1 represents the additional interview done with a health care funder.

The questions which guided the interviews with the partners were as follows:

- What does the social accountability of medical practitioners mean to you?
- Tell me about the elements of this social accountability which have been part of the principles of your teaching over the years in the curriculum.
- What should the university do about developing socially accountable doctors in the curriculum?
- How can social accountability be developed and evaluated in undergraduate medical students?
- Do you think that you are socially accountable? What makes you socially accountable?
- Do you think that professional autonomy is a barrier or a support for social accountability?

6.3 Findings

The participants offered a multi-faceted view of the health care and medical education systems and of their interaction in the production of medical graduates. The academics interviewed were specialists responsible for teaching a range of health science students at both undergraduate and postgraduate level. All three levels of participants came from influential sectors and so their perspectives often reflect their elevated vantage point.

Their elevated vantage point allowed a macro perspective to emerge as a reflective journey from the current state of medicine to the aspirations which they held for new graduates. The journey (later characterised as the road to health) is reflected in the categories which emerged following the coding of the data and act as signposts for this metaphor of the direction in which we need to travel to achieve better health. Five categories emerged from the engagements with

participants and these are presented here with a brief summary of their scope which is further developed later in the chapter:

- **Making meaning of accountability**

The meaning of social accountability for the participants in this part of the study resonates with the ideas first expressed in communities and then refreshed in the student study. The participants reflected on the origins of accountability for those who felt that they are socially accountable practitioners as well as on the manifestation of this accountability in the significant relationships with both the patient and the broader community from whence that patient comes. They expressed concerns about the current state of medicine and the impact that different definitions of professional autonomy may have on the health care of people. Participants offered a number of ideas regarding the state of society and its impact on health care, the status associated with being a doctor and the consequent asymmetrical relationship doctors have with patients and the impact of power in these relationships.

- **Doctors have lost their way.(Acad 4)**

Numerous ideas emerged as being responsible for a negative mood which characterises prevailing medical practice. Perhaps the most sobering reflection has been the idea of medicine's drift away from the patient as centre of their practice.

- **Social accountability '*as a light, lighting the way'* (Acad 7)**

Participants discussed social accountability through many expressions which can be characterised as an illumination for the context described earlier. The light offered through the concept of social accountability is seen through excellence and its call for doctors to look beyond themselves to their patients and their communities. There was a strong focus on advocacy in challenging systems and the urge to look forwards to the possibilities rather than the frustrations.

- **Teaching for accountability**

The curriculum should be supported by pillars of social accountability and knowledge. The environment and teaching space should enhance the broader

learning of students with its intersection of learners, teacher and the context in which patients and community are engaged.

- **Be prepared to 'dance' with what comes to you (Acad 5)**

The dance metaphor used by one of the academics crystallises their vision for what may be achieved for students – undergraduate and postgraduate. The idea of a dance and its implicit partnering with others in a team for best effect brings together a series of discussions relating to the attributes which the participants aspire towards for the graduating doctor. This well choreographed dance allows a vision of relationship and reflection in a complex environment.

6.3.1 Making meaning of accountability

The participants in this third part of the study echoed the expressions of both communities and students that social accountability emerges from the initial relationship the doctor has with a patient. That initial relationship is captured by the eight *Batho Pele principles (Part 1)* which include, with reference to the general civil service, consultation with people, excellent service standards, access to services, courtesy, information to those receiving a service, openness and transparency, redress of past inequalities and value for money (Department of Public Service and Administration, 1997). Two key areas referring directly to health services are professional ethics and confidentiality (Khoza and Du Toit, 2011). The provincial participants emphasised the notion of service in their concept of social accountability. This service to the individual patient is reinforced in the connection to a community:

> *We've got to have a completely different mindset of realising that the communities are not there because of us... we are there because of the community that is there. And therefore, my responsibility to that community is to show them that I care about them, and I come out to them and come and look at the dynamics within that community. (Part 1)*

This different mindset may cause new obligations to emerge as expressed by another provincial participant:

Once you are a doctor and you've qualified, you have a duty and responsibility to ensure that, that that skill, that knowledge that you have acquired is used to the benefit of the society as a whole. By that I mean to say that health care is a social good. So you are one of the small pieces in the jigsaw to ensure that we achieve what is for the benefit of society. So not for personal gain - as an individual, that should be secondary (Part 2).

The image of connectedness through the community and for the community's benefit heralds the emergence of the idea of the delivery of health care being a system. This "jigsaw" puzzle analogy reinforces the idea of a doctor needing to be part of a whole system (in this case the jigsaw) which in its completion provides benefit for the community as a whole.

This idea is elaborated in the following extract:

We all have a role to play. If I work in a system; that's why we do things like quality improvement plans. In my little space where we have a system there'll always be problems but we work within the system to improve it (Part 2).

This is the most direct acknowledgement of the system in which we work. Acknowledging this, the individual's contribution to that system is echoed in many of the participants' definitions of social accountability. Social accountability was characterised by participants as the focus on a responsiveness which enables the use of *your professional skills to provide care in a way that is appropriate to a particular individual (Acad 5)*, advocacy, the priority needs of a community, excellence, social solidarity as well as moving beyond patient centredness to the community context.

The following extract offers a school of thought which expresses social accountability at two levels:

The social accountability with the patient, then the community in the broader picture (Acad 8).

It is this “broader picture” view of health that has already been highlighted in previous chapters by student participants as being achieved through the curriculum *(more wide angled view of things) (See Chapter 5.4.4*).

Many of the academic participants identified themselves as being socially accountable and reflected on the origins of this approach to their work. Some came *to medicine with a bit of an activist background (Acad 1).* The commitment to socially accountable practice was often formed before they entered the medical curriculum either through the influence of a parent’s service to a colonial community, the engagement of a family in the socio- political tensions presented by apartheid or as one participant said *a sense of fairness and justice would be the most important things that have driven me (Acad 5).*

Participants described only limited impact of their medical curriculum when exploring its role in fostering their social accountability and ascribed the spirit of social accountability as emerging from *peri-curricular opportunities (Acad 1)* amongst which may have been rural medical encounters or simply the idea of being at a South African university in a time of injustice which characterised apartheid.

There was a strong sense that the achievement of social accountability is in the engagement of underserved communities with the associated learning processes:

> *I don’t know how you teach it in a medical school. I mean it can only happen through engagement with community in one way or another, whether it’s about, as a kind of minimum, bringing the community into the four walls of medical school, but ideally it’s about students getting out there (Acad 5).*

Regarding this engagement with the community, academics reported mixed responses from students when they were asked to engage with health care at the more basic interaction with the community health worker – *And one of them was completely horrified. She said "No. Why us? Why don't you send nurses? That's a nursing thing. It's not really something for doctors." And the other one of them said, oh she thought that would just be great (Acad 3).* The concluding statement

seems to suggest that some students are responsive to this level of community engagement.

This reflection on a student's perception suggests that students learn early that there are things that are beneath doctors and so are reserved for other lesser members of the health team. Participants engaged with the need for an enhanced team approach amongst doctors because they *think working as a team is quite critical (Acad 12).* Participants suggested that there are few examples of team work in medicine in South Africa currently and the problem may be how the team is developed:

> *At the top (of) the hierarchy of the team here is this god-like creature called a doctor. That is a problem (Acad 12).*

This view was echoed by a participant who suggested that there is little regard for team work in the local context because of the status of the doctor:

> *And we talk about team this and team that, why? Because South African doctors are not working in teams. You don't see team work here, so there is still the power vested in one person with the most knowledge who is expected to be the leader even though there isn't a team. Because the team is not an equal team, you get a doctor and you get nurses and other people underneath (Acad 7).*

Despite this there was an acknowledgement of the importance of team work:

> *We know that health care is a team sport. Managing complex patients requires a team working together (Key 1).*

The expression of the need for teams based on connectedness was emphasised: *when we are talking about relationships with the team and understanding that social accountability is not an individual effort by a doctor. Yes, it's in a system but it's also ideally being part of a team (Acad 1).*In particular, *that the social accountability thing is really getting back to the team work. We are stronger than the sum of our parts (Acad 9).*

One participant reflected that the team allows one to ask the appropriate question of particular situations*: if you are part and parcel of the team, which is also being asked the same question: What is the social accountability of orthopaedics (or any other discipline)? (Acad 8).*

The benefit of team work was described by one academic in the experience of managing diabetes in a public sector clinic. The team consists of many different carers many of whom are able to speak to patients in their home language. Previous extracts have referred to the lack of definition of the powerful role ascribed to doctors in a team but also to the composition of teams. In a multicultural society such as South Africa, this may be an important determinant of the success of health care delivery:

> *I don't think any doctor will include, for example, traditional healers or other team members that serve the community; they'll work in isolation because of their professional autonomy (Acad 12).*

The exclusion of practitioners other than medical may have negative consequences. Professional autonomy was often expressed as a threat to the idea of team work. Many participants whose work was in the public sector suggested that the presence of other practitioners in the work space challenged individual decision making (*your thinking is always modified and modulated by those around you (Acad 5), there's a sort of peer review process going on all the time (Acad 4))* which is seen as the counterpoint to prevalent individualism seen in the private sector (*people work as individuals and they have that autonomy (Acad 5).*

Autonomy was presented as the antithesis of an audited practice domain where there are constant checks and balances amongst peers. One participant referred to this in terms of reflective behaviours:

> *None of us have arrived, we should never arrive. What you need to do is to be measuring yourself all the time and finding out where your strengths and weaknesses are and continually improving them. You need to be doing that in the context of the team within which you are working. And the team is not just about your immediate team it's also about where you*

are in the integrated region (geographical and system). So the people that are referring to you or that you are referring to - are you playing the right role? (Key 1).

Autonomy is important up to a certain point but we need to be accountable for what we do and there should be (an) ongoing audit and we should all be open to audit(s) of what we do (Acad 4).

The building up of these multilevel teams and the role of others in our individual practice may present a challenge to the notion of professional autonomy. One participant described this in relation to other industries where a checklist process has meant a rethinking of the role of certain professionals:

So they destroyed professional autonomy. They said forget about having you as an individual having to remember everything, there is a team here and we each know what our role is and in fact the roles are codified into a series of process steps and we make sure that we all go through those process steps and then we know that the result will be that the plane doesn't crash. Does that happen in health care? It's starting to, slowly, there are more and more checklists, stuff like that are coming into surgical theatre. The challenge of that process of taking a process and defining it and codifying it and turning it into a step-wise checklist process is a direct challenge to professional autonomy (Key 1).

There was an acknowledgement of the tension which is created by current thoughts about professional autonomy:

Autonomy as it is practiced in our settings often allows other individuals to claim some kind of superiority about doing the best (for the individual patient) and it takes always from being socially accountable (Acad 2).

However, there were equally strong voices arguing that social accountability may depend on a strong sense of professional autonomy:

Professional autonomy allows us to be better advocates for our patients because we actually can stand up and speak as a professional, regardless of whatever my employer or anybody else tells me to do (Acad 1).

In the context of advocacy, there remains an element of autonomy which enables the professional to speak out and act on behalf of the patient. There may be occasions when this power ascribed to a professional is a crucial asset in order to enable advocacy and challenges against the status quo:

> *You need professional autonomy in some ways in order to be able to leverage your accountability; you know your larger (social) accountability (Acad 9).*

Perhaps the following extract best illustrates the tensions within the definitions and function of autonomy:

> *I do not believe that autonomy implies free for all. I think there are limitations to your autonomy, and many of us don't see those limitations. Actually we become very cross when those limitations are pointed (out) to us. Professional autonomy as far as it relates to how you interact with your patients, how you reach clinical decisions, management decisions - there is a scope for that but to think that your decisions don't impact on communities is really a falsehood (Acad 10).*

These conversations on autonomy highlighted the privilege afforded to medical professionals in their conduct both towards individual patients and in relation to communities. The following extract offered the expressions of an academic participant:

> *I'm a great believer in the noble profession of medicine. It's a unique profession. It's a unique privilege. And I think we must keep our students on the straight and narrow. I think they've... the students and doctors have lost their way a bit (Acad 4).*

6.3.2 Doctors have lost their way (Acad 4)

This remark early in the conversation with one academic was in the context of believing that doctors have lost their way. It appeared that doctors in clinical practice have directed their path away from the patient.

They've lost, I think, the focus of why they are in the profession of medicine and that is to serve patients. I think often times nowadays they're serving themselves to a large extent, and patients are just a vehicle for that. (Acad 4)

There was a widely held view that the prevailing behaviours were a far cry from the students' attempts at admission to medical school to convince their selectors of their desire to serve the people.

Defining who the community is has become a significant challenge with varying opinions and a broad acceptance that it is more than the patient who presents for the consultation. The reference community referred to in the evaluation framework of THENet had resonance (The Training for Health Equity Network, 2011):

My definitions of community vary depending on whether I'm talking about research, service and training. Service is very geographically defined. Certainly my research I think it's a continental or global perspective as an individual that's my community so (if) I'm talking about severe malnutrition and I'm not focusing on Gauteng it's an international community and in my teach,…teaching commitments as I said again it's probably geographical (Acad 2).

The placement of the individual in a global space is important in terms of the expanding responsibilities. The idea of looking beyond oneself at a community brings into focus the many and varied communities for whom health is a challenge:

I think South Africans just tend to define communities as poor people and rural communities and things like that. We don't see the bigger picture. I just see community as anybody outside of myself. I think that there are different communities and in South Africa they are so polarized that it's very difficult. When you are a talking about communities it doesn't bring one homogenous group of people into your mind, there are so many different communities all of whom have to actually be served (Acad 7).

This participant highlighted the idea that communities are varied, but suggested that all communities have equal value in the consideration of health care. The prevailing view amongst participants was that the focus is the underserved because those who have money are usually able to exact the service they need and often are over serviced.

The notion of different communities was reinforced in the following extract:

> *I think that there's (sic) multiple communities you know and multiple constituencies, you know, and so in a way I would use the term constituency because in a way either they find you, like a community finds you, you know, or you somehow find them and there's a kind of resonance with the issues that you care about. Or you see them and their issues become your issues because you know you are in a relationship with them (Acad 9).*

The idea that the community may find you and enlighten you as the doctor regarding their issues was a vital movement. This idea was echoed in the reflections of both the communities and the students in the previous two chapters of this study. A rural community participant was quoted as saying: *I think in as much as they study medicine they must study people and the community (Rural 1, see Chapter 4.5.4).* This suggested that there was some learning to be done by medical students and doctors amongst communities. The students made this clearer: *you realize that community; it's not what you think a community is, it's what they tell you a community is. You can't get that from teaching, you have to be there and you have to see it and people have to come to you with that information (see Chapter 5.4.2).*

The comment reinforces the notion of constituency in which there is a sense of the community's own agency in defining their destiny. The agency may only be evoked through a sense of empowerment amongst communities. This idea of constituency was emphasised by one of the partners:

> *And you (doctors) have a scarce skill you must acknowledge, a scarce skill. But remember none of the doctors in South Africa learn how to examine anyone without using poor people. In medical schools when you*

do a PR (per rectum) or a PV (per vagina) you practice it on poor people. You work on this social group, which is poor. Now I will not be asking a lot if I say your skill, your knowledge, you are to share it with this group. Because whatever you learnt you used their bodies, their soul and their generosity. So assisting them… we say after practicing on me because I'm poor, once you've qualified and you are rich you should charge me that shows that you are a business man and (it's all) because of your hard work. So it is a system that encourages the exploitation of poor people and it will be a sad day if we allow it to continue (Part 2).

However, the participants in this study offered bleak reflections of the power of doctors and the ensuing asymmetries which inequality brings to bear on communities. The following extract captures the dynamics of the power which the doctor has:

The doctor also is the one who says do not resuscitate, this patient cannot be saved and everybody stops, including the nurses. That's power my friend, that is power! The doctor has that immense power. In health like I said inherent in our qualification there is power. Sometimes I explain it this way, there is no other professional that I know who can tell someone's better half, say "undress" and the better half is there yet there is no problem with them poking and doing whatever because he thinks this guy knows what he's doing (Part 2).

This extract at once highlighted the power and emphasised the vulnerability which patients experience in their encounter with the health services. There was an expression that patients at all socio- economic levels experience this vulnerability in their relationships with doctors. Anecdotes offered by participants who have assisted their own family in their engagement with doctors suggested that this was a common experience until their own professional status was revealed prompting a more engaged conversation with the attending doctor. Unfortunately, this sense of vulnerability was deepened in communities where there are *low levels of personal power (Acad 1*) as a consequence of poverty, lack of education and unemployment.

This imbalance of power may adversely affect the doctor's sense of accountability:

> *First it's for us to be aware as doctors that definitely you start off with a power imbalance and that you actually need to adopt a position of being an advocate for the patient that's actually your role and your responsibility. So number one we need to be acutely aware of our powerful position with patients. Two, we need to inform; I think patient education becomes important in the community. That you have a right to the knowledge about what is to be done at that time and that has got nothing to do with doctor's competence. In actual fact answering questions improves the outlook of individuals or patients of your competence. (Acad 10)*

The doctor behaviours described in the preceding paragraphs were an echo of the earlier comments regarding losing their way. If they are losing their way from the emphasis on the patients' interests, this extract regarding professionalism assisted in a refocus:

> *Professionalism for medical doctors is actually progressive citizenship engaged with your profession (Acad 9).*

The call to doctors to be engaged progressive citizens was not isolated. This engagement implied a need to understand society and the socio-political factors which impact on the marginalised in society. The political issues of racism, sexism, inequality and pollution become *all of these things (that) get played out on people's bodies, you know, in one way or another (Acad 9).*

There was an air of despondency when participants reflected on the current state of the health service and the education system of doctors.

The challenge of a health system which is taking strain from high burdens of disease and an inadequately functioning system formed part of the experiences of the participants:

> *The health system promotes inertia and the best thing you can do as manager whether national or provincial is do the minimum. Don't rock too much. Inertia reigns and if you don't.... Okay it's the one who is jumping*

and doing things and brings him or herself to the fore and then you risk antagonising people and having your head cut off (Acad 2).

This extract reflected many of the participants' views that despite the system not always working efficiently, there were risks associated with trying to do things differently.

Despite this sense of despondency, there was a strong sense of the need for good role modelling from clinical teachers which could drive students to practice in a manner which is socially accountable. Participants expressed the concern that students may be exposed to the negative stimulus through conduct and delivery within the health system which has become very challenging:

I think it's turning it (social accountability) off in some students and I think that our students find themselves in quite a negative space here in the wards, you know with people being rude to them so it's kind of like kick the dog. If someone is being horrible to you and told you that you're stupid and useless and of no value you know? How do you then go and feel good about yourself and uplift the next person who happens to be your patient? (Acad 7).

While this may be the occasional experience for students, there was also an appreciation for the impact that a role model may make for them:

In our situation, there are still special people who overcome the consequences of the environment and still remain really special healers (Acad 4).

6.3.3 A teaching space for accountability

There was an overall optimism for the positive impact a student's journey through medical school may have on the transformation of their outlook:

I suppose embodied in the broader concept of teaching students is trying to enthuse them about all these different aspects. The medical technical aspects but also the social accountability, the humanism of medicine, is absolutely necessary. We could influence students to a much greater

extent. I'm always an optimist. I think we can do that. We may not win with everybody but I think we could win with the majority (Acad 4).

In the winning with the students, teachers who role model a commitment to social accountability is a key factor in teaching for social accountability:

When you're teaching them and something crops up, if one can encourage the teachers and the role-models to explore that little thing a bit more. That's a wonderful time because it's a very spontaneous thing that would have come up in the context of... say a bedside teaching round (Acad 4).

This extract demonstrated the convergence of a prepared role model teacher and the use of an opportunistic teaching event to highlight a socially accountable issue. The impact of a "simple" concept which may have a bigger impact could be used to evolve faculty development in this direction. Another participant teaches that the bedside teaching space is *where you go and get your passion (Acad 5)* ensuring that the patient engagement is the key to stimulate students towards social accountability. There was some emphasis on role modelling for a broader outward looking focus of patient care. This outward view may cause the educators to examine *how much do we teach about resilience, how much do we teach about true team work, working with people like and realizing what is your tolerance for working kind of in an imperfect world (Acad 9).* In this engagement with an imperfect world *if you want them (the students) to see the importance of the stuff of social accountability, the patient relationships, the relationships with the bigger medical system, you've got to model that for them in a way that they look at it and aspire to be like that (Acad 7).*

An important expression from the participants was the need for accountability towards the students by those who teach them. Part of this accountability must be the hearing of their expectations:

It depends on what the students expect. Do we actually communicate the goals before we start with them? Do they feel that those goals have been achieved at the end of it? And do they see a relationship between what we are teaching them and the future, and do the teachers articulate that?

There is often discordance between students' expectations versus teacher expectations. And you find I expect this from my student and the student did not achieve that or rather did not know about it (Acad 10).

The student – teacher articulation was seen as an important part of this transmission of accountability. In many ways the learning of students is directed solely towards success in assessments which students have to pass and this may be due to an atomisation of both the curriculum and the patients in a "Newtonian" approach, while our challenge may be broader:

The body is broken up by the anatomist and the pathologist and they see the body in terms of disease and disease processes and not as a human being part of a community and being part of a broader population in society in general (Acad 12).

The approach to a curriculum needs to be centred on more than a collection of factual knowledge in attempting to address issues of *wellness, broader societal health (Acad 1).* This may be captured in this commitment to social accountability in the learning environment:

Social accountability being one of the major pillars that we base our curriculum on. I do think that it needs to have the same weight as the knowledge base that is required to be a health care practitioner. It's soft and fuzzy and tough to define but I think it has to be there (Acad 11).

This idea of a pillar of the curriculum was echoed in participants' reflections on the selection or recruitment of students into the medical programme:

One of the things is to recruit differently. One of the problems if we go back, is we've always tried to take the most competitive individuals. Well, guess what, you recruit them like that and that's how they'll behave. We want to recruit people who are socially aware and like working in teams and are much more motivated by value than they are by professional admiration. Recruit different people (Key 1).

Admission into medical school is an important point at which to effect the development of socially accountable practitioners. Participants engaged with the criteria for admission of students from a range of perspectives including that class issues may determine that the achievement of a medical degree for many students is a step out of poverty, that rural students should be selected in order to address the deficit of resources in those areas and that we need creative admissions policies which alert us to wider characteristics in our students. Interestingly, there was no mention of academic performance from these participants in the selection process.

There was some discussion of the activities which students engaged with during their time at university. Some of the academics described their own university days as being filled with activities unrelated to the curriculum which enabled them to look at society in a different way as compared with the narrowness of medicine. Others described the university space in the time of apartheid as part of their education:

> *The university environment. And engagement with the university environment gives you an intellectual understanding of the things that you see (in society) and when you start to have an intellectual understanding of the things that you see it starts to give you a framework in which to reflect on the things you see. So it builds on those innate qualities that you say you arrive at medical school with. That's what a socially accountable medical school is! It's about the ability to facilitate the* ***becoming*** *of doctors (Acad 5).*

The space for students to engage in, in this broader university experience may facilitate their development as socially aware and responsive individuals. Another participant took up this idea of involvement in extracurricular activities, relating it to the full student experience:

> *Again I would argue that those kind of activities, not just the partying, but sports clubs and social activities are probably even more important now than in our era (1970 – 1990) because we had lots of those alternatives.*

Young students have less opportunities, so promoting that I would strongly support because those moulded my personality (Acad 2).

In referring to the current context at the medical school the following extracts applied:

The less well defined components of professionalism and there are many issues where you see that. For instance in the community outreach programmes that one put(s) together: how often is it that you get people getting involved in those? But if there are organizational structures being put into place, it's amazing how students get involved. People get involved with the Students Surgical Society[17]*, the Alex*[18] *outreach that they are now doing is now suddenly oversubscribed (Acad 11).*

This idea of getting students more involved outside of their core study programme was expanded:

I believe we can mould a medical student. We need to engage with our students. The individual who wants to be involved in the broader thing in many ways understands this (the broader picture) and they are the kids that get involved in the SRC, in your Students' Medical Councils and now in some of the societies her, like your Surgical Students Society or the Rural Health Society, those individuals see this already. I mean we need to get the other side. Unfortunately it's the majority who don't immediately get involved but they'll participate, but they are not involved (Acad 11).

The provision of the space in which to engage more broadly as a student in university life and in the life of society at large might be an important part of a teaching space for social accountability.

6.3.4 Social accountability *as a light, lighting the way* (Acad 7)

In their definition of social accountability, the participants used varying images. Following on the expression of despondency from the earlier section, social

[17] Student Surgical society is a student organisation which runs surgically related activities with learning for students as well as charity related ventures

[18] Alex refers to the Alexandra township just north of Johannesburg which is an underserved township community

accountability emerged as a renewing light which could be the vehicle for transformation of the current situation:

> *I am seeing it as an overall arch that pulls everything together. That pulls (together) the individual excellence (and) the basic science excellence, I'm seeing it as a light, lighting the way (Acad 7).*

Social accountability then is perceived as multidimensional.

> *So yes, we can be accountable in terms of the engagement with the community and improving the health of the community but there is also a kind of macro level that goes beyond (Acad 1).*

There was a clear sense amongst these participants that social accountability goes *beyond just the individual patient (Acad 4)* and obliges a more communal action.

The double level of accountability within this communal action was reinforced in the following extract:

> *The features of a socially accountable doctor would be a doctor, who number one knows the society and the community he is serving. Number two, knows and prioritises the needs of that community and also knows or looks at or gets interested in the risks which that community would be at (Acad 8).*

This idea of being part of a larger whole was confirmed in the following:

> *And it's recognizing our impact, our footprint. And where we locate ourselves in the world and what we do. So to me it's about being ethical, being in context, being in solidarity you know with whatever we do in our lives. It's also about being consistent with the human rights approach. Umm and I think it's being conscious of where as doctors our power lies in that social fabric. So that we use our roles to you know leverage certain things which are morally and ethically correct (Acad 9).*

This participant went on to issue a challenge regarding where accountability should be directed:

> *But if you are saying are we accountable to the people, are we accountable to the most vulnerable? Are we accountable to our patients who need us to speak out on certain issues of course not! Are we accountable in terms of making sure that this country is going to meet its health goals you know whatever those goals that they've set as a group, we are (Acad 9).*

This challenging comment becomes the basis for reflections on advocacy and action on behalf of the patient. Participants reflected on the idea that few practitioners are advocates and this advocacy needed to be developed. In fact, one perspective was that there is a need for balancing individual patient based advocacy with a focus on the communal resource allocation:

> *I guess the question of how you as an individual balance the rights of your single patients with (in) the broader society in which you are practicing. So resources are finite and need to be husbanded carefully. The clinician is clearly the fulcrum against which burden of disease and the relative therapies (revolve), he makes those decisions. He has to take accountability for those decisions and the resource consumption implications that they have. So the practical implication is to be on the one hand how do you balance being the advocate for the individual's best treatment and on the other hand be cognisant of all your patients in the society and the money, the resources that are consumed in the treatment of those patients, so it's a delicate balance. And as a clinician, you are obliged to think about those things (Key 1).*

The challenge of advocacy was broadened to consider the balance between resource and the individual. An anecdote was offered by one of the participants illustrating that social accountability in the training of a sub- specialist may include teaching them to reconsider their personal positions e.g. a young person with advanced stage and progressive cancer is entitled to an intensive care bed.

The concept of advocacy was further developed through the idea of possibilities:

My philosophy at this hospital is "What is possible?" The art of the possible. There are many problems. And there will continue to be many problems but there are many things that are possible and if you have the gumption and the drive to do something, you can do it (Acad 4).

6.3.5 *Be prepared to 'dance' with what comes to you (Acad 5)*

The title of this category of the data came from a dialogue with an academic in which he stated that one of the attributes a future graduate will need is that of being able to deal with complex situations not least of which is the complexity which arises from practicing in a heterogeneous multicultural society such as South Africa is. Dancing in some South African communities[19] may be the convergence of individual responsibility and the collective commitment to a continuous movement of celebration. The music is all around and all are welcome. The levels of preparation for the dance are varied with some couples appearing to be experts while others are at the novice level. The climate is a welcoming one. The two people who dance together as a partnership must be attuned to each other as they swirl around the dance floor, but they need to be acutely conscious that there are others occupying that same space. Sometimes there may be a bump or two, but this hardly disturbs the rhythmic flow. This awareness makes the dance a fluid expression of creativity and movement of individual pairs in a kaleidoscope of colour. Dancing appears to imply dealing with many different possibilities at the same time.

*We're in a **very, very** heterogeneous community and so you've got to be able to think on your feet and you know, be prepared to 'dance' with what comes to you (Acad 5).*

The promise of the dance is that the graduate of the future can be different to that of the present.

This was borne out in the following extract:

[19] In the South African context, the "langarm" (long arm) dance is particularly popular amongst Afrikaans and so-called Coloured people. The dances are a collection of ballroom and Latin American dance formats. The dress code is varied from formal to smart casual attire. These dances are often held as fund raising events in communities. They are attended by couples but often single people attend and all contribute to everyone having a good time.

> *The students who excite me show certain characteristics. So it's partly the aspirations that I'm talking about - the students who are clearly able to articulate their vision, their views. I mean this idea of critical appraisal, it's important that they are able to take questions and apply their own minds to it (Acad 2).*

This ability to tackle questions which arise in a new and unpredicted way is an important part of the development of a socially accountable graduate. This ability is an important feature of transformational learning (Mezirow, 2000) which in its changing learners' outlooks on life allows the learner to apply new techniques in analysing their world so that *they exercise their conscience when they are making decisions (Acad 4).*

This aspect of informed decision making was expressed by many of the participants as an important aspiration for their students as they graduate through medicine. A hope was expressed that students develop the skill of detailed analysis to enhance their decision making. There needs to be a convergence of the excellence in clinical acumen and the attributes which make for social accountability. One of them hoped that students become more attuned to both the patient and their community:

> *I would want them to be able to **see** the patient... **really see** the patient and **really see** the community and know that they make a choice. See, focus, choice (Acad 5).*

This expressions of being able to see, to focus and then to choose is a notion which connects to how the students understood social accountability. At the end of the chapter detailing the results from the student study, a model of the socially accountable graduate emerged as being a dynamical relationship between relationship, reflection and complexity thinking. The participants in this part of the study affirmed those attributes seeing all of these as part of socially accountable practice. These concepts are not explicitly represented in the emergent model but form the basis of connecting the partner participants with the student participants' expressions.

6.3.5.1 Relationship

The relationship between a doctor and the patient is central to the achievement of health. Participants were of the mind that within that fundamental doctor-patient relationship there needs to be a rebuilding of lost trust:

> *It's the foundation of medicine and... we will need to really reinvigorate that trust between patient and doctor. And focus on it. And I think social accountability is a strong part of that. The public still perceives the profession of medicine as a good one and I think they, to a large extent trust doctors, but it's not where it should be. We could be a whole lot better than we are at the moment (Acad 4).*

Importantly there was a reflection that the academic performance of students does not always match the levels of trust and rapport achieved with patients following qualification.

One of the participants reflected on this relationship idea as being part of a broader networking beyond the simple linear relationship between two people. The wider network of relationships begins to draw out the concept of social solidarity. South African society appears to have lost that sense of solidarity and a participant ascribed it as follows:

> *Social solidarity it was something you lived with (reference to struggle politic). In the white middle class society that's never been a value, it's always been individuals you are out for yourself, we never made decisions about how it's going to affect your neighbour, in particular with the apartheid legacy you know, people at the end of the day are driven by individual selfish concerns and they always assume that at the end of the day aggression can get you whatever you need (Key 1).*

But social solidarity may be a key component in the development of socially accountable practitioners because of the perceived costs which taking a stand often implied. One of the academics referred to this in the extract which follows:

But we are people who are connected to the social fabric of each other and there is solidarity across how we all live our lives. ..... And so I think there has got to be something about nurturing for all of us. It's not like we're asking you to do anymore to put yourself out there anymore than we would expect you to. And we will care for you. That's the other thing because we all need to support each other. I started with this whole thing about solidarity; you know why are we doing this? We are doing it because we are in solidarity with each other. And the communities also have got to do their part (Acad 9).

Solidarity emerged as an important manifestation of the importance of relationships in social accountability so that all participants become equally responsible for nourishing and nurturing relationships – caring for those in need of care and for those who provide the care.

Relationships in the health sector are best reflected in functional teams. The team work idea recurred in the expressions of the participants:

Understanding that social accountability is not an individual effort by a doctor yes it's in a system but it's also ideally being part of a team (Acad 1)

How much do we…, how much do we teach about resilience, how much do we teach about true team work, working with people like.... that the social accountability thing is really getting back to the team work. We are stronger than the sum of our parts (Acad 9).

This strength often resided in the demands of team work to engage with different people who have often come together randomly.

The relationships are interesting because it's about having relationships with people who are different to you. I think that always having relationships that are based on differences and respect (Acad 3).

These relationships within the team and with individuals must form the basis of the student practitioner's reflective practice. The achievement of this was one of the aspirations which the academics have for the students who they train:

> *That we've got students who are not just confined narrowly to patient-doctor relationship(s). That they do ask questions. That they're not easily intimidated. That if they see something in their work environment that is not right, that they should raise it and not feel intimidated. I would really like to see that in our students and doctors. And if we can encourage that way of thinking, it opens up to so many things... that they will continue in their professional practice... asking those questions... "Am I doing...?" and I think we should all be introspective like that "Am I doing the right thing here? (Acad 4)*

6.3.5.2 Reflection

There was a strong desire to develop practitioners who are capable of asking the questions raised above. The deliberate practice which emerged from these iterative episodes of reflective and subsequent action enhance the practice of medicine.

> *But I think that kind of activity gives me hope that perhaps if they are able to think critically they will be more able to act critically(hmm). So one aspiration is more engaged students, more critically aware (Acad 4).*

The process of reflection was about the development and enhancement of excellence:

> *I think that reflection and deliberate practice encompasses my excellence component, because if you are doing that reflection you are improving yourself for the benefit of your patient so yes I think, I think it does, I think I would probably be more explicit about that, that this is built on a basis of competence (Acad 7).*

There was a warning that in inserting reflective practice into a curriculum one must guard against driving an action oriented process which is entirely based in clinical activity rather than in the health care system.

Inextricably linked to these ideas of competence was the concept of doing better all the time:

> *I guess for me it's around that always thinking about what I can do better but it's trying to have that reflection on the multiple levels and not just about what I can do better to manage the patient's clinical problem but what can I do better in terms of making a difference in the systems and at times such as this clinic I work in (Acad 1).*

6.3.5.3 Complexity thinking

Ongoing reflection allowed the practitioner to appreciate that all aspects in health care and wellness are interconnected. The role of academic clinicians was to *help students to see that we can't change a whole system but by changing one thing in the system that we can fundamentally change the way the system is. Which may in fact provide bigger change (Acad 1).*

The understanding of complexity amongst participants varied but spoke commonly to the need for students or prospective doctors to have a flexible approach to solving problems:

> *The complexity one is an interesting one for me because I think the complexity issue is the ability to have your... your world view and your own sense of right and wrong challenged. ....Does it just reflect the willingness to embrace change, for example... So if you see a scenario which* ***is*** *not what you would normally expect... your ability to identify that and to be able to change and respond to that (Acad 5).*

Whatever the final dimensions of a model of social accountability for the practice of individuals entailed it would have to take cognisance of context:

> *I think in this context in South Africa you have to hang it on the Bill of Rights and Constitution, if we are gonna stay in this country and if we are gonna be citizens of this country. We are citizens with a little bit of extra knowledge. It's about citizenship (Acad 9).*

All of these ideas resided in the capacity of the teachers to translate them into learning. Throughout these conversations there was an expression of the need to develop the ability, within the clinical teachers, to seize the ideal teaching moments to connect clinical excellence to the greater benefit of the society, as well as to link the medical diagnosis with the social and political dimensions of the patient's well being. There were echoes of a transforming teaching paradigm to enable the growing of a generation of change agents.

This development must happen in the context of a university which is fully engaged with communities. Some of the participants highlighted that the university does not always have relationships with communities which are reciprocal and equally engaging in nature. In order to change this there is a need for more work in this area:

> *There should be specific engagements with the communities because that's how we can make it demonstrable - how the students can learn etcetera*

> *I think the excuse has always been that we don't know who the community is and we don't have a community and so on. Some of it comes as an excuse and some of it comes from people wanting to define the community narrowly and I think we should be engaging with specific communities but as the university we should have accountability to a broader community (Acad 1).*

The accountability to the broader social community was best served with a transformed paradigm from the very hierarchical structure of the health and learning systems. This hierarchy, first referred to by the students in both its negative and positive dimensions may create a system with a very sluggish response to a changing context. A participant described this as follows:

> *That rigid structure turns out to not be very responsive to patient care, not very patient centred but is professor centred rather than patient centred and it turns out not to produce necessarily terribly good results. It certainly doesn't create iterative circles of knowledge and learning and so what typically happens in the industry is that they are re-engineering*

themselves constantly based on feedback loops, based on measurements, you know data and measurement that tells you what's going on, we don't have any of that (Key 1).

These circles of knowledge were considered to be important in the building of relationships at different levels including university and community, university and professional community and the university and the health system, particularly in rural environments where facilities may be less well developed for the professional. One of the partners reflected on this concept:

A partnership where training of doctors and nurse(s) is only one small aspect. There's the issue of research. There's the issue of health economics which we are grappling with. Secondly, we must understand the strengths and weaknesses of both. And then mutual respect for what each partner is doing or tries to do and understand that. A formal agreement on what are the areas that we are going to work together on and how it's going to be done. And who is going to carry the costs (Part 1).

This extract developed the notion that engaging in partnerships is part of the grappling with systems in an effort to ensure that they work. However, the economics for the individual practitioner still framed many of the choices they made. The call by some partners to address the plight of the poor as a return on the investment made by the poor for the practitioner's education and training was made in the ongoing challenge of the cost of private health care in South Africa. There was an anecdote that between two cities in South Africa, the victim of a motor vehicle collision who sustained a head injury with a subdural haematoma may be managed in the private sector within an hour with little long term effect whereas, the absence of a neurosurgeon in the same region in the public sector placed the patient at increased risk due to the many hours spent before the patient received the required attention.

This tension between the public and private sector was clearly demonstrated here in the experiences of this victim in terms of access, but there are more subtle processes at work within the private health care system. Some of these were

reflected in the expressions from the participants about private practice being about self enrichment. In reflecting on professional autonomy, there was a sense that while it may facilitate the ability of the practitioner to act in the interests of the patient as an advocate there is also the temptation to inappropriate servicing of the patient in what one participant called the *moral hazard (Key 1)* in which the asymmetry of information prevents patients from fully engaging with the choices which the practitioner makes on their behalf. This two way relationship is further complicated by the third party insurer being the party responsible for the actual disbursement of any payment for services rendered.

6.4 The Road to Health

The theoretical concepts evolving from the engagement with partners in the medical education project are best described through a journey metaphor. The title used for this section is borrowed from a time honoured tool in the Primary Health Care practice environment: The Road to Health Card. This monitoring tool has encouraged generations of mothers in the care of their children as a visible token of their children's growth through the early childhood years. The image of a road to health also suggests a new destination in the conception of health as proposed by Huber et al. (2011) who suggest that health is the ability to adapt to the change circumstances of disease. Their definition suggests that health is part of the community's resilience which allows adaptation to both internal and external environments (Huber, 2010).

The image of the road describes the participants' reflections of the need for movement from the present state of medicine in which *doctors have lost their way*. There were significant expressions of what is needed to take medicine away from this place to a new space.

Social accountability is represented as a light of excellence which shines on this educational endeavour moving it towards a renewed professional context in which health for all is the focus. This light enables a reflection based on an academic participant's aspiration that students are able to see more deeply than the illness affecting their individual patient: *I would want them to be able to* ***see*** *the patient...* ***really see*** *the patient and* ***really see*** *the community and know that they make a*

choice. See, focus, choose (Acad 5). This triple jump analogy which deepens understanding may be likened to the conceptualisation – production – usability (CPU) model which underpins the evaluation of an institution's social accountability (Boelen and Woollard, 2009). How we see the problems and their context may refine our conceptualisation of the graduate we produce, what we focus on may enlighten the process production of the graduate and the choice we make may allow a new promise of the graduate's meeting the needs of the community into which they will emerge (Boelen and Woollard, 2009; Boelen and Woollard, 2011).

Social accountability illuminates the journey from the current context through a process of teaching for accountability in order that our graduates emerge into a transformed professional environment (Figure 6.1).



Figure 6.1: The Road to Health – reflections and aspirations of partners in medical education

This aspirant road to health may be characterised as having three phases:

- The current context

  This would imply an analysis and reflection on the state of medicine as has happened in this study. The emergent themes highlight the asymmetry of power between the patients and their doctors. These doctors have lost their

way in becoming more disease than patient centred. Health care has been reduced to a commodity to which the poor have limited access and those with a little more are subject to excessive demands of cash. The social inequality becomes a significant determinant of health. There is a sense that a relationship will need to be developed with communities in order to change this current reality.

- Teaching for accountability

  The need to refocus the educational process on development of teachers to ensure that social accountability forms part of their teaching at the bedside, allows a renewed emphasis on the core knowledge required by students for graduation. This core knowledge must be developed around the priority health concerns which communities themselves have declared earlier in this study. Community engagement through the location of education within communities needs to form the basis of developing this accountability model. This type of education should be more than just the location; it needs to empower the communities within which it happens. The outcome of this is the development of advocacy as a key attribute for graduating professionals.

- A transformed professional

  The educational partners have echoed the students' characterization of the need for an engaged reflective practitioner capable of complex thinking. The graduate at present emerges into the context in which the doctor appears to have lost his or her way. There was a recurrent theme emergent from this data which suggested that there are new attributes required of the medical community which will allow a changed health practice domain. The idea of a transformed environment means that professionals need to be engaged in these iterative circles of knowledge both for their ongoing professional development and also to become more aware of the feedback loops at play in the systems in which they work. There needs to be a growing awareness of the context in which they practice to facilitate a better stewardship of the health resources representing a new sense of citizenship. The concept which emerged is engaged citizenship which forces change agency. One of the partners reminded us of the meaning of *docere – the one with knowledge*

(Part 2). The more commonly accepted definition of the word implies the calling of doctors to teach[20]*.* It is this meaning that has emerged as committed mentorship which the profession is called to renew in the transformed medical environment.

Social accountability then becomes the lens through which this road to health is interrogated. Central to this notion will be the sense of social solidarity which must characterise the profession.

6.5 Summary

This chapter represents the expression of the aspirations of the partners in medical education as a final dimension in the exploration of social accountability amongst the stakeholders in the quest for global health. These partners have echoed many of the perceptions held by both community and student participants. The centralisation of relationships as part of complex adaptive systems is a recurrent theme. This idea is developed further in the unifying framework in Chapter 8. The next chapter will discuss the evaluation process followed to establish the trustworthiness of the models presented in the last three chapters.

[20] http://medical-dictionary.thefreedictionary.com/docere

Chapter 7:
Proceedings of a National Evaluation Seminar

7 Proceedings of a National Seminar

7.1 Introduction

The preceding three chapters recorded the findings regarding social accountability from the research amongst community members, students and the partners in the educational process. From each set of data, a theoretical model emerged which was described in both written and graphic format. This chapter will describe the evaluation of these three models. A fourth unifying framework will be described in the next chapter. A national seminar was convened to evaluate the process through which all four theoretical models were developed and the extent to which they are an adequate representation of the data.

7.2 Evaluation of a theory

Parse (2005) suggests that the evaluation of a theory has two facets, namely, structure and process. The history of the theory and its development, the foundational elements upon which it has developed and the relational statements which make sense of the concepts all form part of the structures of the theory (Parse, 2005). Amongst the features which reflect an appropriate process in the development of theory are semantic integrity and simplicity, coherence of the theory and its pragmatic use both in effectively guiding practice as well as further research arising from the theory (Parse, 2005).

In dialogue with Parse, Fawcett (2005) suggests that the criteria for an adequately developed and stated theory include significance, internal consistency and both empirical and pragmatic adequacy. The latter refers to the utility of the theory in connecting the data to the theory and the relevance of the theory for practice (Fawcett, 2005).

The nature of the theoretical framework which emerged was guided by the principles outlined by both Fawcett and Parse (Fawcett, 2005; Parse, 2005).

Following the emergence of a theoretical framework, it may be tested through a variety of processes. Glaser proposes that the evaluation process should include a reflection on whether there is a clear link with the data presented for its development (*fit*), the theory must construct a method of viewing the particular issue being studied (*works*), it must apply to a real context (*relevant*) and it must be able to evolve as new information is garnered or situations alter (*flexible*) (Charmaz, 2000). Another approach may be through a critical reflection process using five questions proposed by Chinn and Kramer (2008):

- How clear is this theory?
- How simple is this theory?
- How general is this theory?
- How accessible is this theory?
- How important is this theory?

The evaluation process is important in order to place the theory in the practical reality of social accountability as it needs to be valued and practiced in the context of the various participants (Chinn and Kramer, 2008).

7.3 Methodology

A national seminar was convened for the purpose of evaluating the theoretical models which emerged from each set of data collected in the different parts of the study: community, student and partners in education. In addition, the unifying framework was presented for consideration and validation in this seminar.

The national seminar was selected as a process for validating the theoretical models which emerged in this study to allow national thinkers in medical education to engage with the models. Theoretical sampling was employed to ensure that the most conversant thinkers in medical education would examine the models proposed. The seminar was used as a format to allow the group members to relate their own ideas of the trustworthiness of the researcher's assertions in the

model to those of others in the group (Bryant and Charmaz, 2007; Corbin and Strauss, 2008; Creswell, 2014). This was seen as providing a richer context for establishing authenticity for the models over the use of individual in-depth interviews for evaluation.

Each framework represented the convergence of the theoretical concepts following the identification of categories from the coding process. The frameworks are themselves representations of the relational statements and connections between the categories which emerged. Each of these three frameworks was presented to the group with a brief oral presentation describing the supporting categories and their emergence from the initial analysis of the data. This was followed by a written reflection completed by each of the participants in a prescribed period of 15 minutes. The reflection was guided by a series of questions presented on a document with space for open ended responses (See Annexure J). The concepts proposed by Glaser in Charmaz (2000) were merged with those suggested by Chinn and Kramer (2008) to develop the questions used in the reflection for this evaluation. The questions posed were as follows:

- Does this theory fit the context of social accountability emerging from the categories identified?
- Is the theory relevant and important?
- How flexible is this theory? How accessible is it?
- Does this theory work in your context of health sciences education? How general is this theory?

Participants were afforded time to critically reflect on the conceptual models presented and write their reflections on a prepared document. Part of the reflection from the panel following these questions was that these were conceptual frameworks rather than formal theory. This was noted in renaming the various graphics offered in this thesis.

Following the presentation of all three initial conceptual models, a discussion was held about all three and the participants shared their initial written reflections with the group. There was vibrant discussion on the validity of the framework offered.

The researcher acted as facilitator of this discussion and provided any clarifications which were sought about process in the study. This was followed by an opportunity to edit their original thoughts or to provide new comments which may have been stimulated by the discussion in the group. Both the original reflections as well as the post discussion comments have been collated as part of the analysis of the evaluation seminar. The written reflections were collated in an Excel spreadsheet in order to establish the level of concordance of opinion regarding the validity of the emergent conceptual frameworks (See Annexure K). Both initial comments and any additional comments were clearly indicated in the spreadsheet.

The final session of the seminar commenced with a presentation of the proposed unifying framework and a description of its emergence from the three original conceptual frameworks presented and interrogated earlier. Again participants applied the four questions to this theoretical framework and recorded their reflections in the document provided. This was followed by a discussion of their reflections. The seminar was concluded with an opportunity to modify the reflective document or to record new thoughts which may have been stimulated through the discussion.

One of the study supervisors participated in the entire seminar as a scribe. The final discussion of the unifying framework was joined by the second supervisor through an electronic voice connection from Canada.

7.3.1 The evaluators

The participants were drawn from five of the nine provinces in South Africa. These five provinces are host to all of the eight medical schools in the country. While the participants did not formally represent their institutions at the seminar, they did come from six of the eight national medical schools.

Table 7.1: Demographics of participants in the national seminar to evaluate emergent theoretical frameworks

Educationalists	Senior education manager/academic	Leader in regional and national discourse in health sciences education
	Academic	Teacher in health science education unit for undergraduate and postgraduate medical programme
	Academic/Manager	PhD. Current interest in humanist pedagogy
	Programme Director	Educationalist coordinating an integrating course in medicine
Specialist Clinicians	Family Physician	National leader in rural health and medical education
	Family Physician	Coordinator of medical students' community based education
	Physician	National leader in health science education and curriculum development
	Physician	Clinical educator
Other	Pharmacist	Discipline leader and participant in national discourse of transformative learning in health sciences education
	Nurse	Coordinator of medical students' skills training
	PhD Student	Studying social accountability supervised by one of the other participants

7.3.2 Seminar proceedings

Participants were introduced to each other in a neutral manner to avoid the different levels of qualification and experience from affecting the discussion. This

was done because the participants occupied all levels in the academic hierarchy of their institutions, namely, senior lecturers, professors, senior managers and senior professors. The engagement by the participants throughout the seminar was robust. The panel's general comments will be presented first, followed by comments directed at each of the frameworks which were interrogated and evaluated.

7.4 General Comments

The panel acknowledged the contribution which this study makes to the national discourse in social accountability. The process which was followed in the course of the research was considered to have a sound structure and the emergent concepts were generally validated.

Social accountability in both conceptualisation and its development and practice has the features of a complex adaptive system. This idea was welcomed by the panel of participants who confirmed the need to use a systems approach in addressing social accountability both at the level of the individual and the institutions which produce these professionals. In accepting this as a paradigm in which this study may be placed, the panelists centralized the role of relationships in the achievement of social accountability – emphasising that relationship centred care and systems should be placed in the foreground of the explanation and discussion of the models which this study has proposed.

The communities, students and education partners framed social accountability and their relationships with doctors in value laden terms such as love and respect, relationships and professionalism. The panel challenged the conceptual frameworks for not focusing on these aspects sufficiently and urged that these merit greater attention in their final editions. In subsequent revisions of the frameworks, these comments have been addressed and greater clarity given in the chapters where these are presented in this thesis.

Linked to these values and the systems in which they are at work, the panel also suggested a more clearly defined discussion of boundaries regarding the conduct and the outcomes of the study. In particular, the localisation of the study context to a single institution needed to be discussed in terms of its impact on the

boundaries between Wits University and other institutions both at a technical and at a more reflective level as well as the detailing of what forms part of this study.

The final conceptual models which are presented in Chapters 4, 5 and 6 are the result of the critiques offered by the panelists at the national seminar. Their role was to evaluate the extent to which the resulting frameworks represented a reasonable idea emergent from the data. It was through this seminar discussion that the patient – doctor relationship regained a central position in both the community concept model and then became a separate proposal in the unifying framework. The revision of the student model arose out of the challenge that I had appeared to sacrifice authenticity for the symmetry of a graphic representation. This led to the development of the model presented in the final monograph.

A clinical educator noted with concern the absence of a specific reference to team work as a concept which is important for social accountability. Another referred to the unifying framework as a modified code of conduct. Both of these ideas were noted but not included as part of the final reflection of this study.

7.4.1 Community Concepts of relationships and expectations

All participants affirmed the fit of the model. There was a call to deepen the understanding of the role of the social determinants of health especially poverty. The participants acknowledged the central role of relationships both at the individual patient – doctor level as well as within a system of networked relationships which is characteristic of ubuntu. The nested nature of the model was affirmed in the discussions of the seminar. The framework presented for consideration by the panel is shown in Figure 7.1.

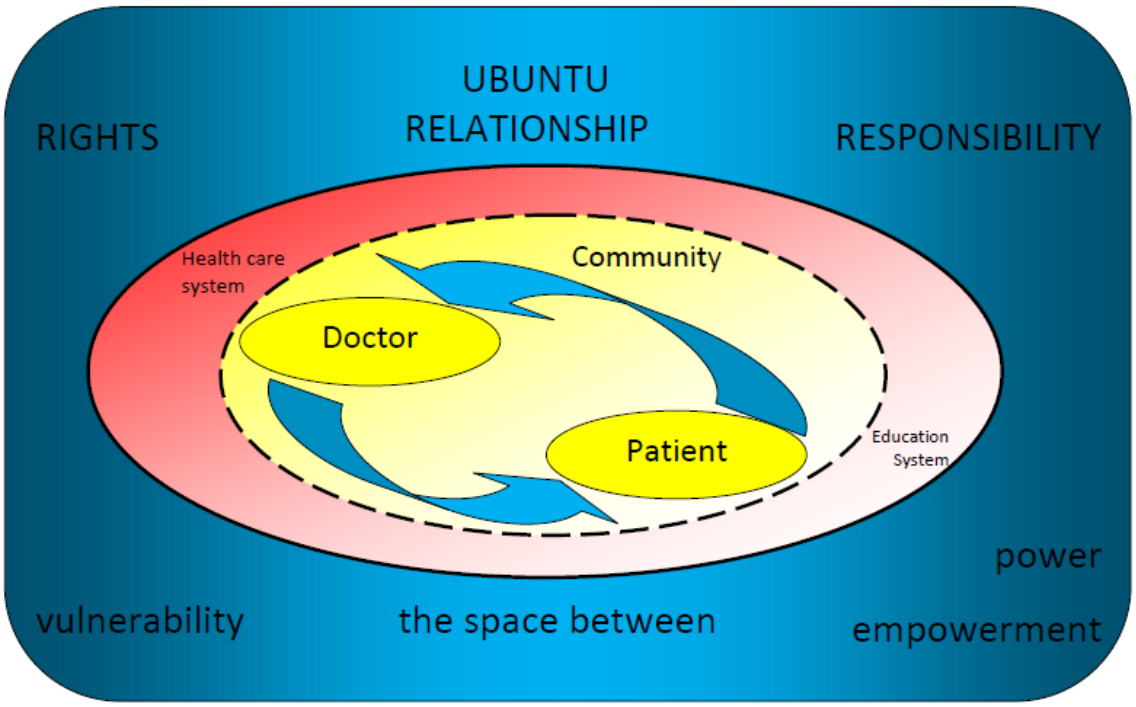


Figure 7.1: An initial representation of the community concepts of social accountability presented for evaluation to the panel.

The theoretical model has relevance to the context of educating medical professionals by drawing attention to the community's conceptualization of social accountability in their relationships with doctors. This understanding forms an important building block for the construction of curricula. The relationship of the university with the community is an important part of understanding communities.

Participants affirmed that the model presented was flexible, accessible and applicable to a variety of contexts of education of health professionals even beyond medical students. There was a suggestion that there be a more explicit description of its wider application in further iterations of this model.

This model has been adapted following the comments made in the national seminar. The revised model for the community concepts of social accountability was informed by these conversations and is presented as the final representation in chapter 4 (See Figure 4.5). It is presented here as Figure 7.2 for ease of reference.

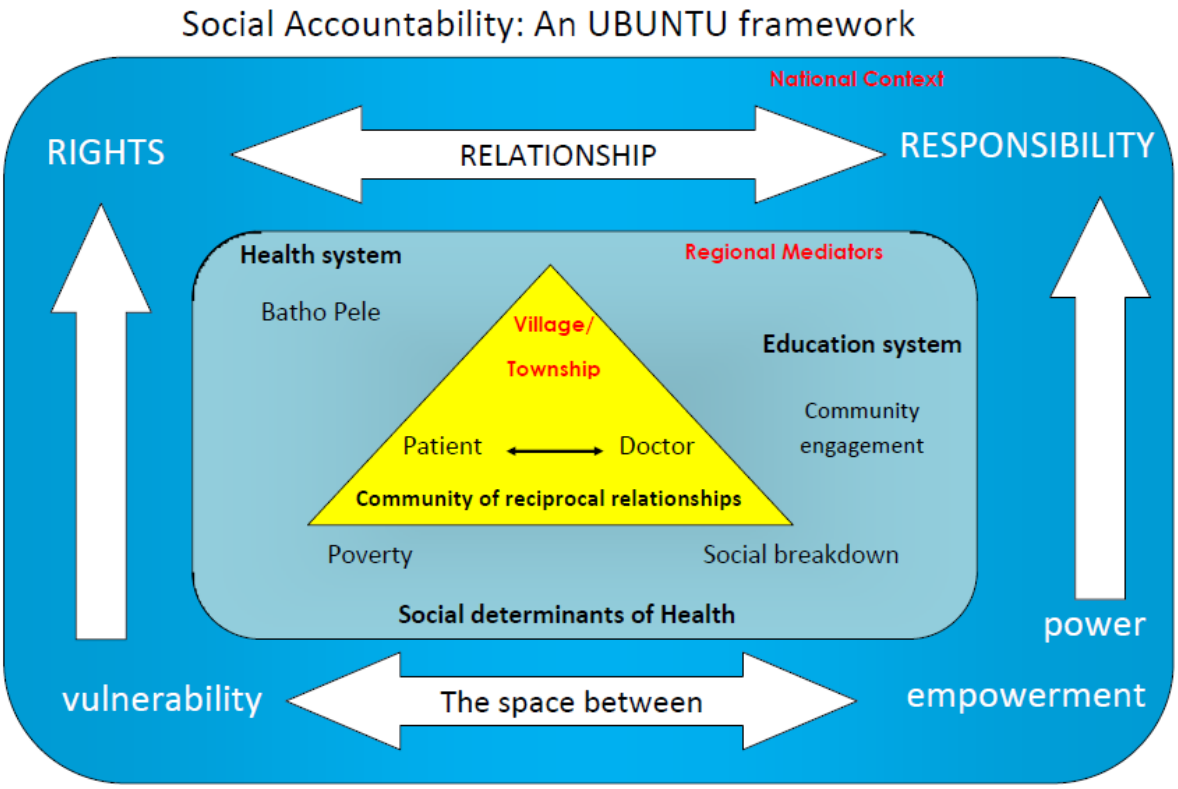


Figure 7.2 (cf Figure 4.5): Social Accountability – an ubuntu framework emerging from community engagement

7.4.2 The vision of students

While many of the participants affirmed the fit of the framework, there was a challenge that the categories should be more explicitly linked to the structure of the model. The importance of power in these expressions should also be highlighted more clearly in the model. This original model is graphically represented in Figure 7.3.

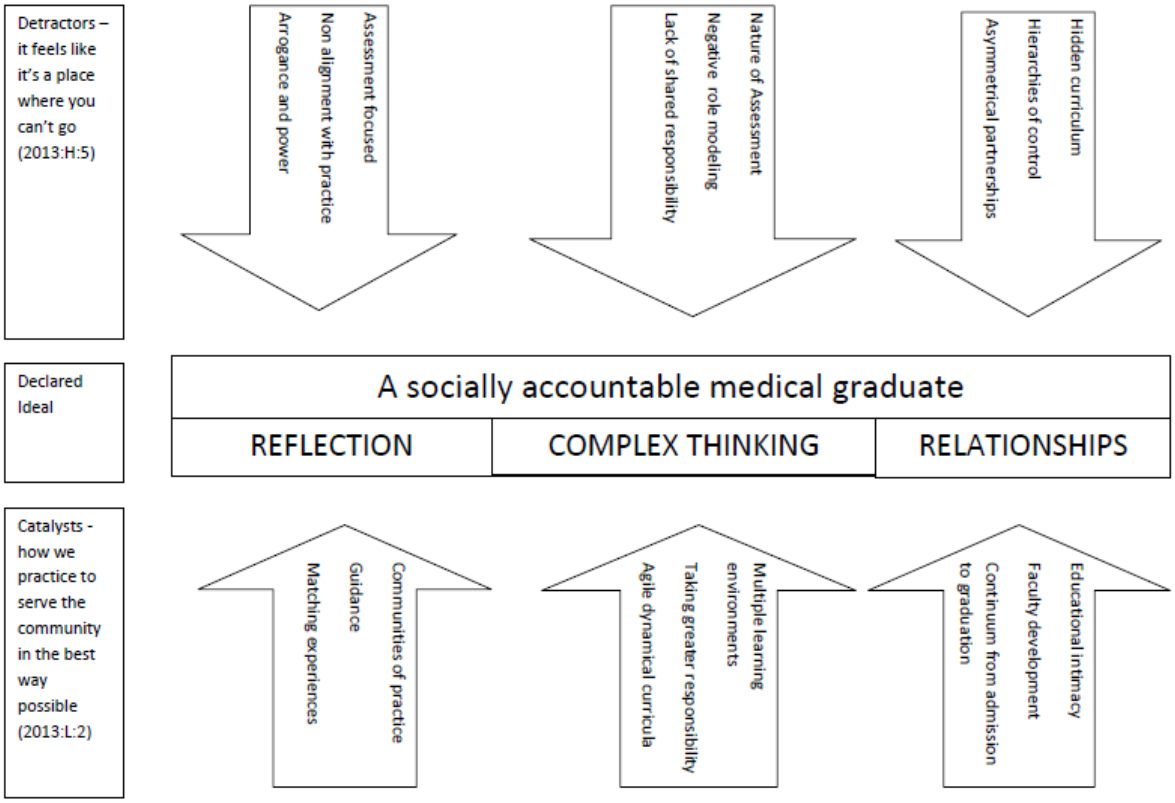


Figure 7.3: Initial representation of student expressions of social accountability presented for review to the national seminar

All participants reflected positively on the relevance of this model to the journey which students undertake through a curriculum en route to professional status. They highlighted the importance of role modeling and the potential for empowerment of students as partners through the shared responsibility described in the model. The model appeared to address an educational system which may place it in tension with the health system in which students and professionals may be active.

The panel confirmed that this model was flexible, accessible and adaptable to many of the educational environments of which they were aware. There was, however, a sense that the model could be expanded as the data sometimes appeared to be too compacted – there was a need for closer connection of the

data to the model. There was a call to include the community and patient relationships more explicitly.

The model of the student expressions has been substantially modified to address some of the process issues raised in the national seminar. This final representation is presented in Chapter 5 (See Figure 5.3). It is reproduced here as Figure 7.4 for ease of reference.

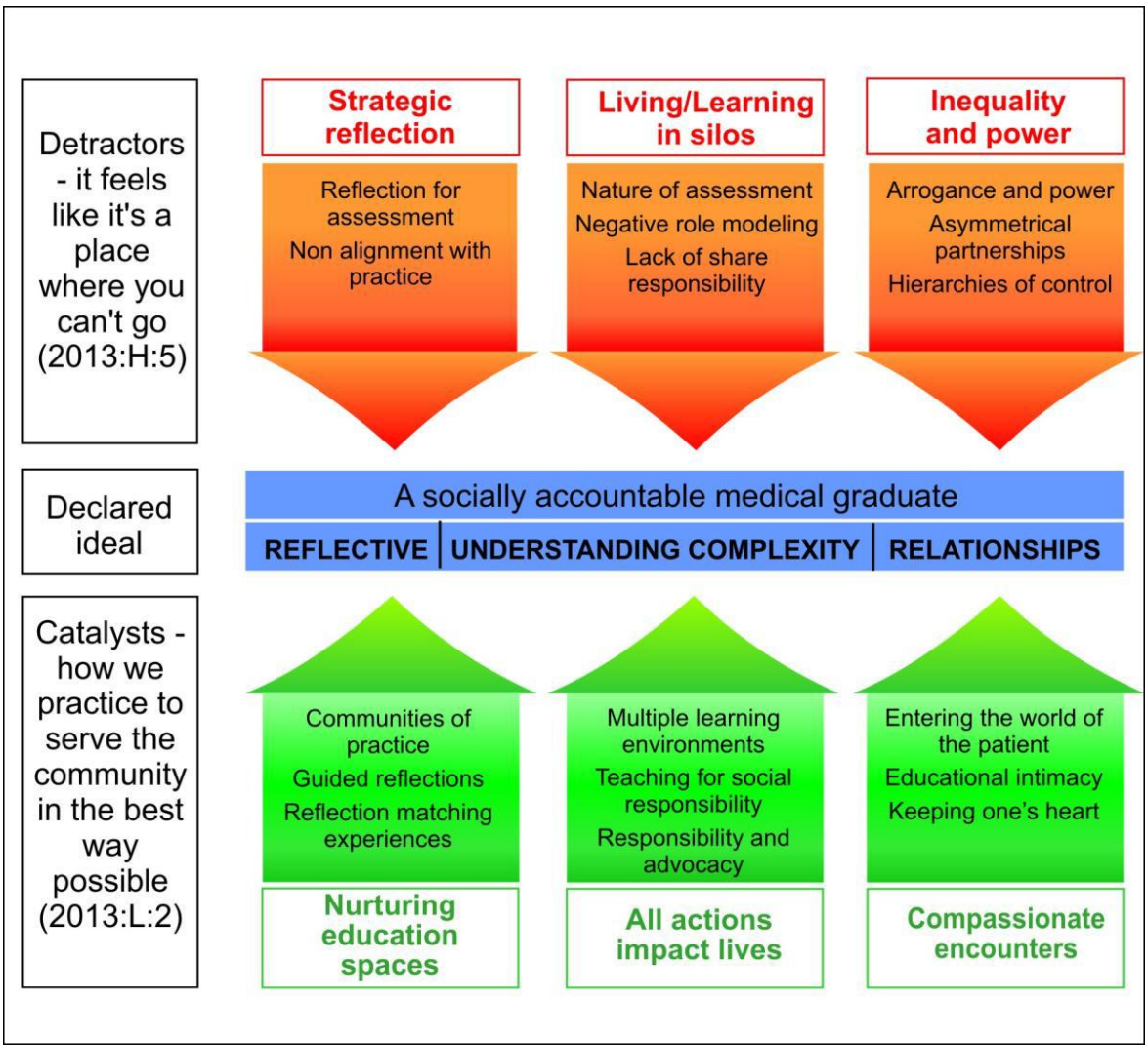


Figure 7.4 (cf Figure 5.3): The tension between catalysts and detractors in the education of a socially accountable medical graduate

7.4.3 The Road to Health

The title and content of this model was well received by the participants. There was resonance with the idea of a road but the links with the data were challenged more substantively than in previous sections. The panel affirmed the relevance of the model in so far as it offered a sense of destinations with suggested sign posting along the route in order to achieve that goal. Importantly, the model was perceived to show opportunities for moving from theory to practice. The panel reflected on the original model represented in Figure 7.5.

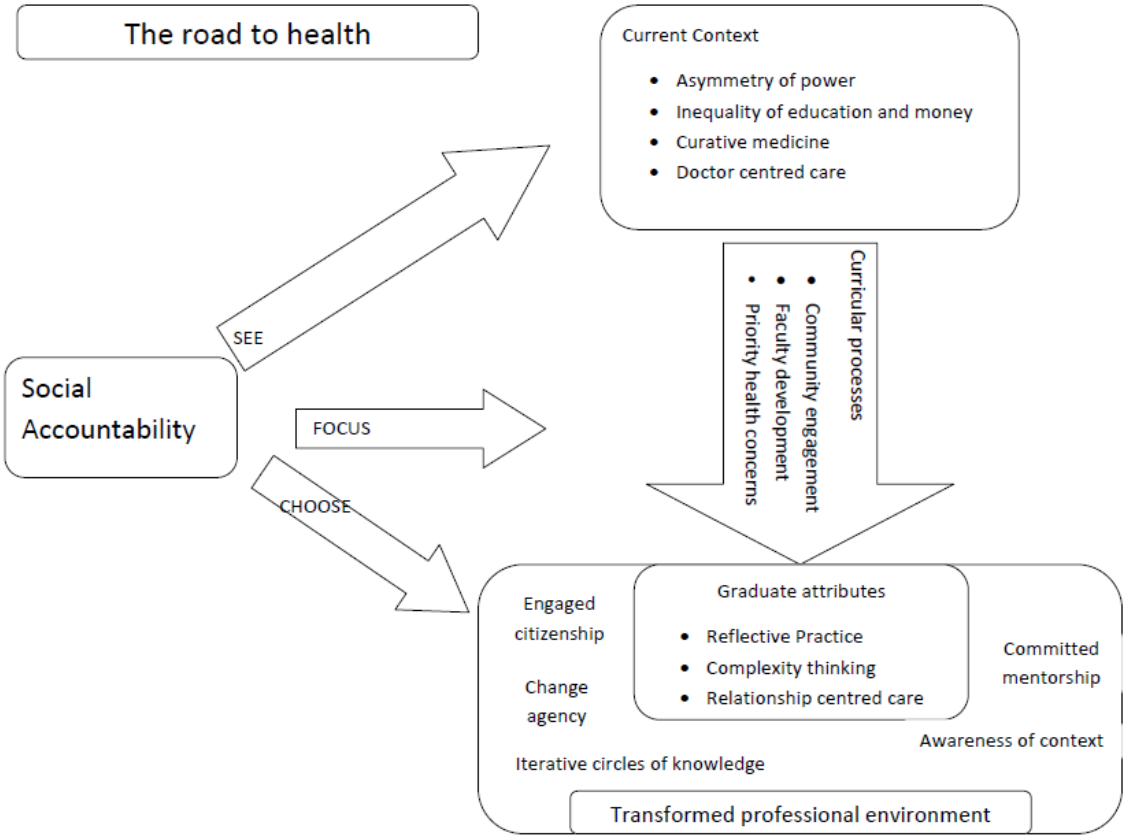


Figure 7.5: Original representation of the road to health – emerging concepts from partners in medical education

There was a general feeling that the model was flexible, accessible and applicable to a more general environment than the study context of a single institution as well to other health professions disciplines. It was felt that it may achieve greater appeal with some modification and explication.

The reflection which followed these comments resulted in a revision of the model based on more detailed exploration of the data offered in the partners' study. This resulted in a revised model to explain that data with more detailed descriptions of the relations between the concepts. The refined model is presented in Chapter 6 as Figure 6.1. It is reproduced here as Figure 7.6 for ease of reference.



Figure 7.6 (cf figure 6.1): The Road to Health – reflections and aspirations of partners in medical education

7.4.4 A unifying framework for advancing social accountability

This unifying framework was presented to the panel after they had discussed the three frameworks emerging from the study of communities, students and education partners. The panel responded enthusiastically to this model and the extent to which this framework had emerged reliably from and represented a synthesis of the previously presented models of community, student and partners' expressions. Areas which required more refined connection were the inclusion of the patients as a central fulcrum around which the many complex relationships assert their leverage.

There was agreement amongst the panelists that the model was relevant, but questions did arise about whether these were practical or not. Some panelists argued positively that the absence of an obvious hierarchy of the statements allowed educators and practitioners the opportunity to strategically choose priorities which matched their particular context and environment. The model offered the opportunity for those with different initial interests to find a starting point which matched their particular strengths.

The graphic employs the picture of a flower with many overlapping petals. The ability to use the petals in the graphic differently ensured the adaptability of the model. Many participants suggested that it could be applied in a variety of contexts to good effect. The challenge of the model may be the ability to operationalise its concepts, particularly in the tertiary hospital training platforms. The complexity of the educational platforms will require adaptation of the model to ensure greater relevance and applicability. The strength of the model is in its framing of central relationships which enhance interactions at community based levels of education.

There was evidence of a developmental lens being used to view this particular frame of social accountability. One of the panelists suggested that it may form the basis for a transformative humanistic pedagogy. To facilitate this engagement with the model, there was need for more textual connection with the previously emergent models.

The evaluation seminar provided substantial reflection on the refinement of this framework in order to enhance its relevance and applicability to the health sciences education landscape. Following this refinement, the model is presented in the Chapter 8 and offers a synthesis of all the models which have been discussed before.

7.5 Summary

This chapter has reported the proceedings of a national evaluative seminar called to examine three models which emerged from data collected in research conducted amongst communities (Community Concepts), final year medical students (Student Expressions) and the partners in the educational process (The Road to Health). The panel of experts affirmed these models as well as the framework which sought to unify these models in order to advance the idea of social accountability. The next chapter will describe the development of this unifying theory.

8 A framework to advance social accountability

8.1 Introduction

The convergence of African humanism as reflected in ubuntu and a systems approach to social accountability is fundamental to the framework for the advancement of social accountability which is proposed in this chapter. The harmony of the voices expressed in the conceptual models which emerged earlier in this study brings into the foreground an understanding of the concept of ubuntu as a philosophy through which the relationships governing a community may be deepened. Understanding ubuntu allows an appreciation of the connectedness of individual persons with each other through their relationships within the broader community and the systems in which these relationships have meaning (Khoza, 2011). These systems form the basis of achieving wellbeing for all.

In order to advance the social accountability ideal which is emboldened by this quest for well being, the development of individual practitioners with an understanding of the relational nature of their practice within the complex adaptive systems of health care becomes critical. The establishment of an educational environment which supports this becomes essential.

The framework which emerges from three models developed in engagement with communities, students and education stakeholders suggests that in order to nurture a new generation of professionals, there is a need to redefine the context in which this growth may occur. The framework offers ten dimensions of this context which may be characterised by being able to SEE the realities of health and its delivery, FOCUS on relationships in education and practice as the unit of engagement and to CHOOSE an enhanced educating community through which to achieve social accountability. These are represented in Table 8.1.

Table 8.1: Unifying framework for the advancement of social accountability

SEE	Prioritise the social determinants of health
	Engage communities for empowerment
	Align curricula to priority health concerns
FOCUS	Revitalise the relationship of trust with the patient
	Promote relationship - centred community based learning
	Nurture relationship - centred educating communities
	Reconstruct professionalism for engaged citizenship
CHOOSE	Build a progressive and engaged student community
	Create faculty development for socially accountable role modelling
	Commit the faculty community to becoming change agents in defined communities

This chapter will discuss this convergence of ubuntu and complex adaptive systems and explore each of the ten proposed dimensions of the framework individually.

8.2 Ubuntu as a social paradigm

Ubuntu was raised by a rural community participant in the context of expectations of university teaching:

> *I was thinking about, at medical school when you are teaching these doctors you need to teach them ubuntu as well so that they know what to do when they come to communities (Rural 2).*

Coming at the end of a discussion on the community members' relationships with doctors, this extract invites us to explore more deeply the meaning of ubuntu. Molefe (2011) offers two maxims which have become popular definitions for ubuntu. The first is the Mbitian maxim "I am because you are and since we are, therefore, I am". The second is the Nguni aphorism "umuntu ngumuntu ngabantu" or in English "a person is a person through other persons" (Molefe, 2011). It is almost certainly this concept of the doctor's ability to insert into a community as

integral to that community which is being invoked by the participant's call in the extract above. Khoza (2011) suggests that one's relationships with others are the foundations of one's personhood or humanity.

Khoza (2011) invokes the dance metaphor while discussing leadership which is guided by this African humanism. In speaking of leadership he asserts that neither the leadership nor the followership in any organisation is responsible for success individually. Khoza (2011:129) asserts:

> *The dance is not a mechanical thing: it occurs in the theatre of consciousness where leadership and followership become of one mind.*

The "interactionist quality of leadership" implies that individuals bring their personal traits into the relationships which are the foundation of leader – follower relationships. Just as in the dance, leadership implies a series of relationships. The dancer may relate to a single partner but together they navigate the interactions with other couples on the dance floor in a kaleidoscope of colour and a vibration of rhythm.

These relationships framed within an ubuntu world view are characterised by, amongst others, values such as solidarity, compassion, respect, human dignity and collective unity (Mbigi and Maree, 2005). This is highlighted by the following two extracts which help to deepen the sense of ubuntu expected from an urban community participant and a provincial government education partner:

> *... to have humility. To know that you are dealing with a human being who is not feeling well and you are there (Urban 2).*

> *All health workers... if they can relate to their communities with dignity and respect... and respect that dirty, tattered, tacky man for what he is - a human being and not for what you perceive him to be, I think we'll be more caring health workers (Part 1).*

A student who acknowledged the difficulty in defining socially accountable practice, argued that being socially accountable should not be something a

practitioner does on the side but should become part of their routine as it currently is for some:

> *You see examples of people taking accountability or showing that … giving back to the communities and examples of people contributing to their respective communities and trying to establish some sort of ethos of growth in the community, you know ubuntu and that kind of thing. But you don't umm it's not like an easily definable thing where now we are as a group, a people, who are socially accountable people, and that's what we do as a… as everyday thing that we do you know. You often see it as this is a big company and on the side we do some social responsibility. We are medics and on the side we do something. So it seems to be like on the side kind of thing (Students A10).*

Khoza (2011) positions the altruism implicit in the above extract as a central tenet of ubuntu which together with a service of the common good become important elements of African humanism. He places ubuntu in tension with the prevailing individualism which characterises much of the Western humanism paradigm (Khoza, 2011). This idea is carried through many writers on ubuntu (Molefe, 2011; Mbigi and Maree, 2005). Mbigi and Maree (2005) describe the interconnectedness within a community being an essential part for effective function of any individual part of that community.

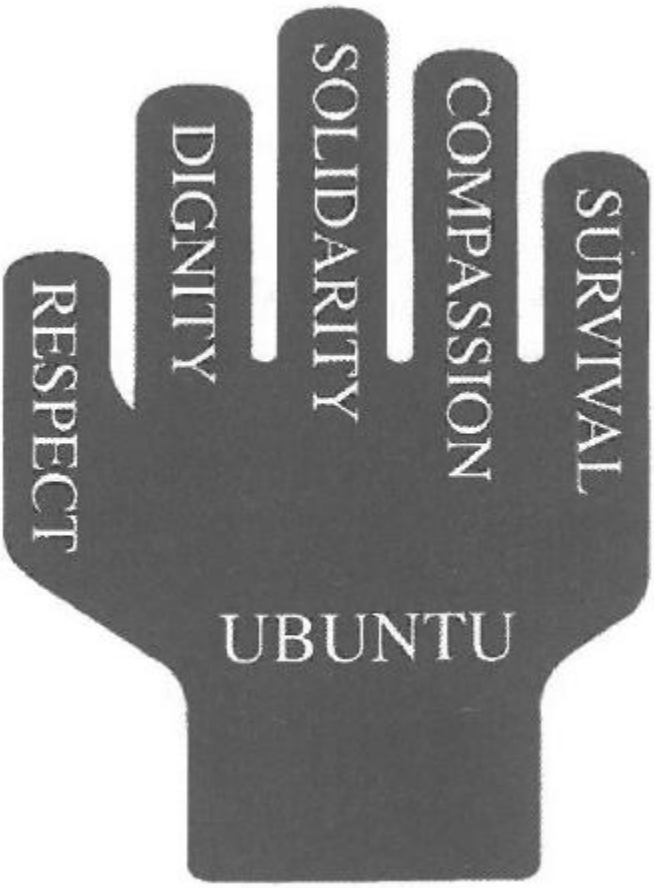


Figure 8.1: Collective Fingers Theory graphic (Mbigi and Maree, 2005)

This model of ubuntu emphasises the interdependence of different actors in an ubuntu based society. The assertion that the thumb cannot function separately from the other fingers is echoed in the fact that all parts of the systems in health care are interconnected. The collective fingers theory, proposed first for an African transformative management environment, illustrates the values which characterise the ideal ubuntu based society. The implementation of this model reinforces the idea of relationship which is central to ubuntu (African humanism).

Building relationships is central to the systems of health and wellness in societies. This student participant, reflecting the idealism with which he set out at the beginning of his training, relates the increased importance of relationship in the context of managing sick children during the paediatrics clinical clerkship:

> *Coming into medicine it was all about being nice to people and to patients and showing the other side, not just the clinical. So for me I've realized*

that that is most important to pediatrics, you realize that you have to lose your inhibitions and be there for the children … there's so much more you need to do with the children (2012 A1).

The extract shows the realization that building relationships with children is much more important for their healing than it may be for adult patients. Yet there is also a sense that these are the little things which may have impact and are not always recognised for the impact which they may have on the greater wellness of patients whom they encounter.

The following extracts from three different students show an incremental understanding of the concept of relating for impact on health. This student reflects on their contribution making very little difference:

We think that our small contributions aren't gonna make that much of a difference… I mean we think to ourselves that whatever little I do isn't going to make much of a difference in the greater scheme of things. You think well it's just another patient what's my contribution gonna do in the bigger scheme of things? (2012 A10)

While this student also appears uncertain of the impact that her contribution was making, there is an understanding that many small actions may have an impact which is greater than the sum of these actions:

What difference am I making? Something that will only take two minutes of my time! What difference is it making to the greater community? I don't think it has to be big to make an impact. I mean it's kind of cliché but if everybody does those few little (actions) then the impact itself will be greater (2012 A2).

This student's extract demonstrates a growing confidence of the effect of joint action and the greater systemic effect of small initial events. The extract reflects the place of empowerment as perhaps a final step in the development of the sense of impact:

If each of us are empowered in our own life in a unique way there'll be no need to figure out the greater good because I think there's a saying that if you take care of the pennies, the pounds will take care of themselves. The greater good will just come of itself if you just take care of a small little thing (2012 A9).

These extracts reflect on the impact of little "actions" which when done in concert may have a greater impact. The emergent pattern in students' understanding of the impact of their empowerment is clearer in the following extract from another group which shows the understanding that small actions may have larger unpredictable consequences:

The quality improvement project that we did in IPC[21], although they were a tall order, they made one or specifically me realise that with the little resources that we had or that we have rather we were able to make a change, even if it is a small change but we were able to make a change. That's the realisation, I started from there on. (2012 D3)

This last experience of limited personal resources being able to create effective results is echoed in other studies on work in rural based environments (Worley et al., 2006). The success of these experiences is often based on a network of relationships as described by Prideaux et al. (2007) in their symbiosis model. The symbiosis model places the student at the centre of a series of relationships which intersect suggesting that understanding relationships is beneficial to their experience (Prideaux et al., 2007). The view from an ubuntu perspective is that being in relationships with others creates meaning for the individual whether they are student or part of these many intersecting systems (Khoza, 2011; Mbigi and Maree, 2005). The relationships described in this symbiosis model add to the basis of viewing medical education as a complex adaptive system (Worley et al., 2006).

Williams and Hummelbrunner (2011:136) define complex adaptive systems as follows:

[21] IPC is the Integrated Primary Care clerkship. A primary care clerkship conducted at district hospitals both urban and rural.

> *Complex adaptive systems (CAS) comprise semi-autonomous agents that interact to form system wide patterns that are not obvious or predictable from studying the properties of that system. CAS are said to display self-organisation, because there is no central command structure.*

There is an echo of this thinking of agency within a system in the comment from a community participant:

> *The doctor alone will have to suffer the consequences of the (ill) feelings of patients but let's not forget that it is from the receptionist... it goes to the auxiliary nurses, ... it goes to trainee nurses, then you finally go to the doctor*." (Urban 3)

The community demonstrates their understanding of the encounter with health care as a reflection of a system of many parts where the different actors bring different signals.

A key informant critiques the current approach to the systems nature of health and wellness as follows:

> *(The current health system) certainly doesn't create iterative circles of knowledge and learning and so what typically happens in the industry is that they are re-engineering themselves constantly based on feedback loops, based on measurements, you know data and measurement that tells you what's going on, we don't have any of that. (Key 1)*

The call in this extract is for the health, and possibly the education system for health, to be increasingly responsive to feedback and the changing nature of environment. The concept of "iterative circles of knowledge" confirms that both the system and the feedback which is generated is about the relationships which exists between the agents in the system appreciating the signals and responding to the emerging patterns. Williams and Hummelbrunner (2011) suggest that there is a constant interaction between the container (the bounds of a system within which agents operate), the significant differences (issues which precipitate self-organisation) and the transforming exchanges (the spark between the agents)

which is implied in the extract above relating the constant feedback loops being addressed through reading the data.

Advancing social accountability in health demands that we acknowledge that it is a complex problem with multiple agents in varying and dynamic relationships with each other who each have a similar goal but a different interest in pursuit of that goal (Mennin, 2010; Williams and Hummelbrunner, 2011; Glouberman and Zimmerman, 2002). Ensuring that these agents act in concert for change means that the individual is less important than their relationships within the system. This idea represents a challenge to the Western idea of individualism and may lead to a reconstruction of professional autonomy.

This study has explored the perceptions of three groups of stakeholders in the South African health and wellness system as part of an attempt to understand how they relate in terms of their understanding of social accountability. This framework for the advancement of social accountability has used complex adaptive systems and ubuntu as the background for the ten proposals (see Table 8.1) which will now be expanded further. Each proposal will be presented followed by a reflection on the emergent patterns which support it derived from both the data of this study and the literature. These proposals are shown in Figure 8.2 below.

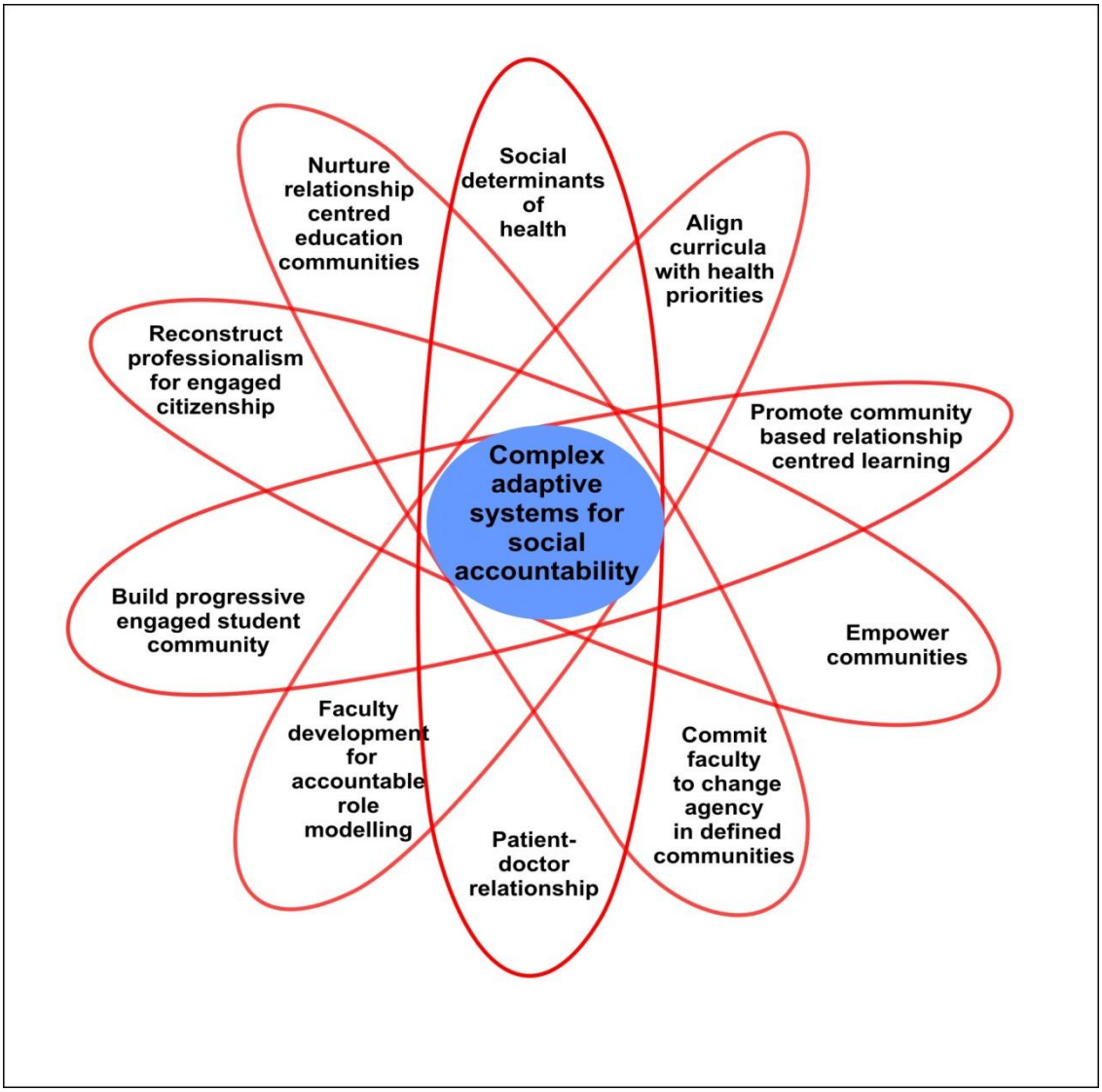


Figure 8.2: Advancing Social Accountability: a unifying framework

8.3 Proposal: Prioritise the social determinants of health

8.3.1 Emergent patterns

The community participants centralised the social determinants of health as being a major factor in their experience of health or disease:

> *You know, poverty causes a lot of things; stress, unhealthy decisions (another participant mutters "definitely), all of these things and we don't eat healthily, it causes some issues of diseases inside of you. So most definitely I think poverty plays a big role (Urban 3). (See Chapter 4.5.2)*

Poverty forms the backdrop for much of the social inequity referred to by the WHO Commission on Social Determinants of Health (CSDH, 2008). It is also the cause of much of the asymmetries that the poor experience in their relationships with their doctors referred to by all stakeholders who participated in this study – the asymmetries of power, education and socio-economic status:

> *In South Africa and Africa we are dealing with people who are disempowered economically, disempowered educationally as well. So it forms part of the vulnerability that number 4 was talking about that these people do not have or are not fully aware of the recourse they can take if they've been wronged (2012:D:3).*

The imbalances of power deepen the negative impact of the social determinants of health on the community's experience of health care. The partners in the education of doctors shared similar reflections:

> *There is enormous asymmetry of information when you go to see a doctor and you don't know what's wrong with you and you don't know what the (appropriate) therapies are. The problem is moral hazard and the moral hazard is made worse by the asymmetry of information.... So that sitting around in the consultation room are two people (doctor and patient), neither of them are really concerned with stewardship of the costs, one of them is concerned with their own income (Key 1).*

The asymmetries have an impact in both the public sector and the private health care environment. There is an impact in the relationship at the level of clinical care as well as at the economic level of transaction.

A student participant captured the role that educational institutions have in informing students of the context of an unequal health care system which is part of a much larger discriminatory legacy:

> *Particularly just to underscore in South Africa and the history that we come from - the lack of health facilities some communities are exposed to. I think will (it would) be socially negligent if an institution does (did)not conscientise it's trainees to address those needs. Then what is the whole*

> *purpose of being a doctor in itself if you don't as an institution… because* ***Wits Faculty of Health Sciences is directly placed to influencing what kind of doctors we become in the future as well.*** *(emphasis added) (2012: D: 3)(See Chapter 5.4.1)*

Academic participants made a call for the orientation of prospective doctors towards the government policy frameworks such as the National Development Plan which seek to address these historical deficits both in health and in the broader social domain (National Planning Commission, 2011).

There are international movements which echo this idea that the achievement of health equity is predicated on the amelioration of the inequalities prevalent in society at large (CSDH, 2008). The Commission on Social Determinants of Health suggests that moving in this direction will entail an increase in civil society involvement in the issues around the social determinant, the political empowerment of communities and a redirection of the socio-economic forces towards greater education from early childhood and improved social support (CSDH, 2008).

At an education level, there have been attempts to bring medical students into closer contact with underserved communities in an effort to conscientise them to the experiences and realities of these communities (Meili et al., 2011; Sandhu et al., 2013; Dharamsi et al., 2010a; Dharamsi et al., 2010b). Dharamsi et al. (2010b) highlighted five themes in their qualitative study on international service learning experience which increased the sense of advocacy for the participants. The themes included the benefits of experiential learning especially coupled with critical reflection, a more practical awareness of the impact of the social determinants of health and, perhaps most importantly, that the poor were resourceful in their own right.

This capacity of poorer communities to act in their own interests is captured in the next proposal.

8.4 Proposal: Engage with communities for empowerment

8.4.1 Emergent Patterns

Alperstein (2007) argues that the community organisation has skills and knowledge which could benefit the framing of the curriculum for health professions education. In order to harness this potential benefit, there would have to be a determined partnership with the community which leads to increased empowerment of the community – often by acknowledging them as a source of skills and knowledge.

These relationships as described by Dharamsi et al. (2010b) may be the intersection of the empowerment of communities and the advocacy which health professionals are expected to master. An academic participant in this study has described this as follows:

> *What I would want is the sense of relationship and advocacy. The sense that, you know, this is not me against the patient, or for the patient. This is me and the patient together trying to solve this problem and me trying to support and help the patient and how I can best do that (Acad 1).*

Another academic described social accountability in terms of involvement with communities:

> *When I was younger that was the archetype of being socially accountable. You're with the community; you are doing this with community organisations. You are taking up social issues and engaging with politicians and other stakeholders (Acad 10).*

The immersion of the educational institution in the community becomes an important vehicle for the empowerment of the community. The need for this is demonstrated by a discussion during this study where a community in which the university staffs a hospital have not identified that Wits has an active role in the running of that hospital.

The Commission for Social Determinants of Health suggests, amongst others, the following actions (CSDH, 2008:18):

> *Empower all groups in society through fair representation in decision-making about how society operates, particularly in relation to its effect on health equity, and create and maintain a socially inclusive framework for policy making.*
>
> *Enable civil society to organize and act in a manner that promotes and realizes the political and social rights affecting health equity.*

This type of empowerment is often best achieved through the asset based approach offered by McKnight (1997). Mcknight (1997) suggests that an asset based approach to community development allows responsible empowerment which eventually leads to capacity development within the respective community. This is matched with the ladder of citizen empowerment proposed earlier (Arnstein, 1969) (See Figure 2.2).

An important focus of this process needs to be the advocacy which focuses on the development and empowerment of marginalised and vulnerable communities (Dharamsi et al., 2010b).

Part of this empowerment of communities may be to change their focus from disease to new concepts of health and wellbeing. These concepts are further developed in the next proposal which links conceptions of wellbeing to the definition of health priorities.

8.5 Proposal: Align curricula to priority health concerns

8.5.1 Emergent patterns

> *Health for doctors is a negative state—the absence of disease. In fact, health is an illusion. If you let doctors get to work with their genetic analysis, blood tests, and advanced imaging techniques then everybody will be found to be defective—"dis-eased" (BMJ Group Blogs) (Smith, 2008).*

This provocative statement challenges the 1948 definition of health by the World Health Organisation:

> *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*[22]

There is a growing debate about the meaning of health which has its origins in the discussion around moving wellness discussions from pathogenesis to salutogenesis (Pauli et al., 2000b). The renewed discussion highlights the issue that using the 1948 WHO definition may render most people unhealthy because of the changing disease demography from acute to chronic conditions (Huber et al., 2011). Huber et al. (2011) go on to reflect on the complexity of defining health, acknowledging the intersections of different interests and cultures, but prefer a definition which addresses adaptability and the capacity to self manage as central to wellbeing. Huber (2010) in the earlier report on a conference hosted by the Netherlands Health Council referred to health in terms of equilibrium as reflected in homeostasis, allostasis and resilience. That conference was the forerunner of the renewed construction of health in terms of *an inner resource, capacity, an ability, a potentiality to cope with or adapt to internal and external challenges ….even without nutritional abundance of physical comfort*" (Huber,2010:14).

These reflections are important because the definitions of a nation's health priorities will need to take this changing landscape into account. This is reflected in part in the South African Development Plan's vision for health in 2030. The plan envisages greater longevity for South Africans in the context of improved equity, efficiency, effectiveness and quality of the health care system with a reduced impact being felt of the social determinants of health (National Planning Commission, 2011). The quadruple burden of disease which faces South Africa is also a key feature of attempts to deliver health care (Chopra et al., 2009; Mayosi et al., 2012).

[22] http://www.who.int/about/definition/en/print.html

The perspectives offered by community participants have also highlighted the wide extent of social and disease related ideas which have impact:

> *Behavioural patterns, our lifestyles, we are corrupt, too corrupt. Err... too much of alcohol* ***...*** *too much of alcohol and too much of drugs, and we smoke a lot of cigarettes and marijuana amongst others. Err conflicts, conflicts in the yards, personal conflicts in the home, conflicts in the yards that eventually bring about stress and stress will distribute a number of illnesses. (Urban 3)*

The social fabric of the communities interviewed clearly has a great part to play in the creation of well being, but there is also a strong sense of these communities taking responsibility for the fixing of the deficits:

> *We have to deal with these issues as a community. We need to just sit together and try to educate one another concerning those things, therefore maybe it would be resolved somehow, some difficult issues. (Urban 3)*

While communities have articulated the cause and responsibility in the context of declaring health priorities, students have the impression that the focus of the learning may be misdirected:

> *If my (examination) paper is going to ask me about ... like twenty marks on sarcoidosis when TB*[23] *is the problem... there's a problem (with the examination). ....Fifth year is where it becomes relevant. But before that you are asking me fine print. Rare things, because how is that preparing me for (clinical work). It's frustrating us as well... in our soul... (2013: I1)*

The frustration is expressed in relation to an assessment process which does not match the conditions common to the students' learning environment. There was a persistent call from students for the curriculum to be informed by the statistics of health in the country.

[23] TB is tuberculosis

This linkage between a region's health priorities and the curriculum forms an important component of the social accountability evaluation tools which have emerged through global consensus and formulation (The Training for Health Equity Network, 2011; GCSA, 2010). In the section of the evaluation framework, which asks education institutions about the difference which the institutions make to the health of the people, the following aspiration for curricular alignment is declared:

> *We have a positive impact on priority health and social needs of our reference population. In partnership with stakeholders we contribute to the transformation of health systems to be more relevant to the health needs of our reference populations (The Training for Health Equity Network, 2011:22).*

In engaging with our reference populations, the data in this study has revealed that for all stakeholders with an interest in the community, the basic unit of analysis for measurement of successful engagement is the relationship with the individual patient. It is this relationship which forms the proposal which follows.

8.6 Proposal: Revitalise the relationship of trust with the patient

8.6.1 Emergent Patterns

Throughout all the engagements in this study, there was a strong call by participants to make the patient central to the processes which may build social accountability. Indeed, the category which emerged in the community study spoke of the need to reclaim the consultation as a "place of love and respect" (See Chapter 4.5.1). This call emerged from the deep sense of vulnerability experienced by community members in their interactions with the health system:

> *When I come to the doctor, I have an illness problem. I want to get here, sit down and the doctor listens to me and then after listening if the doctor does not understand what I'm saying then he can have all the apparatus they use to check me as it is necessary for him, with care and love (Rural 2).*

In bringing the “illness problem” to the doctor, there is an expectation of being heard and, importantly understood. The levels of trust which doctors appear to enjoy have their source in the vulnerability of patients both in their illness and their levels of understanding of disease:

> *Patients come to us - they don’t know what to expect. This position of the doctor, most importantly, is about the life of the patient, when I go to a doctor it’s because my life is threatened. A doctor is like an insurance, if you go to a doctor and he says you are fine. You go home happily because you think your life has been insured by the doctor, you are not going to die. Now that is power my friend. (Part 2)*

Community members place a great deal of trust in their doctors and yet there were experiences of that trust not being returned through the behaviour of doctors. This is part of the tension of where doctors’ primary interest may lie:

> *They’ve lost, I think, the focus of why they are in the profession of medicine and that is to serve patients. I think often times nowadays they are serving themselves to a large extent, and patients are just a vehicle for that. And it's a generalisation that I'm making but I'm quite conscious of that (Acad 4).*

> *There’s the cash conundrum and the question that comes up is at what point is there a tipping point at which doctors start looking at the patient as a, as a source of money only (Key 1).*

The idea of service in tension with self interest is a recurring theme through the conversations amongst communities, students and the partners. Some of these have expressed the need for doctors and students to be reminded of the privilege that is granted through their practice of medicine:

> *I've always thought medicine is a very special profession because the level of trust is enormous. If you think about it, people are placing their lives in your hands and maybe even more so in our (South African) context because patients are very dependent on us and for that to be successful, there needs to be that trust. It’s a remarkable profession and*

we shouldn't forget where we came from and we need to engender that incredible feeling of responsibility, trust, um, and the privilege that we have as doctors to look after people. It's not conscious enough and maybe something that we need to preach more - the privileged position that we're in. (Acad 4)

This sense of privilege needs to be matched by the sense of compassion towards patients. A student participant wistfully reflected on the process of losing compassion through his training and then reaching a compromise in the balance between compassion and cynicism:

My biggest fear was losing my heart and losing my compassion. That was my biggest fear of doing medicine. It was such a big thing that was spoken about you become desensitized, you become callous is not the right word, cynical. So through the years I've kind of watched myself and I've changed a lot. I've been so scared that I had lost my heart and I've watched myself become desensitized and cynical over the years. … I suddenly realized in paediatrics, I found out that I hadn't lost my heart. It was still there and it was an incredible realization. But it had died, a little bit was different, it wasn't as strong, you know maybe the heart and compassion wasn't as strong as it used to be, but it's still there and it's kind of sad that over this time I've lost a lot of that selflessness and idealism but maybe becoming a bit more realistic with still having a piece of my heart maybe that has made me more effective. Because it's all fine and good to want to save the world but it's not feasible, it's not practical. So I find a little bit of compassion with the cynicism is a bit more practical perhaps in our society. (2012: A1)

The depth of reflection offered by this student participant shows a maturity beyond his years. There is an essential optimism embedded in the ability of a novice professional at the cusp of his emergence as a graduate professional to offer this reflection. The education system is obliged to seriously reflect on this in order to ensure this level of reflection is nurtured and that it provides an environment which allows the growth of less cynical doctors. This expression, in fact, speaks directly to the deteriorating nature of relationship between the patient and the doctor. A

relationship which is not always experinced with compassion by the patient. This student participant reflected on the different perspectives of patient care and participation in their own care which are taught and then subsequently experienced by students in the clinical environments:

> *I think if you probably looked at our training, we are made more aware that you can't dominate... you can't tell the patient what they have to do. It's their choice and the power, therefore, should lie with them in making that decision. I think that it's difficult for us to practise it like that because we get taught it like that but then you're in the hospital with all the other doctors who were not taught the same way that we were. In practise you are learning to treat patients almost in the way that they are treating patients. I don't think enough of them have shown us how to be good to your patients and actually come down to a level where we don't feel like you are a more powerful figure than the patient... I don't think that enough of them have shown us that. (2013: E:2)*

There is a convergence of the need for collaborative practice with patients and the need for this to be role modelled in the students' clinical training.

All of these expressions bring into the foreground the basis of the relationship between patient and doctor or student and then the relationship between student and doctor. These relationships which are essentially the basic building blocks for the care of patients offer the opportunity for delivering health care in a non-linear engagement (Suchman, 2006). Allowing the relationship to become central to patient care frees the consultation to become a place where gesture and response enhance both the delivery of care and the levels of collaboration achieved between patient and care giver (Suchman, 2006).

When these basic units of care are repeated for the patient, their perception of improved care grows:

> *Tomorrow when you come maybe there is another doctor and you don't know the doctor you see (Urban 3).*

*And sometimes at the hospital you don't meet the same doctor the second time. You are **very** lucky (general agreement in group) **very lucky** (huge emphasis) **if you meet the same one** (Urban 2).*

The relationship as a continuous experience is seen as instrumental for improved care as well as learning. Flexner (1910) argued at the start of the twentieth century that the basis of a medical school's training process should be both continuity of the teachers in service of the patient and student as well as creating the possibility for students to follow each patient very closely. This closeness which enables greater relationship with patients is captured in the symbiotic model of a curriculum (Worley et al., 2006; Prideaux et al., 2007).

These notions have become central in the growing international movement of integrated clerkships. Hirsh et al. (2007) urge that clinical learning must be anchored in the continuous care provided by students relating to the patient throughout their encounter with the health care systems from admission through the hospital stay and in the follow up period.

The relationship between the individual patient and their doctor in their initial clinical encounter and beyond must become the essential unit with which the community based educational engagement must be measured. This idea of relationship in community based education is developed further in the next proposal.

8.7 Proposal: Promote relationships centred community based learning

8.7.1 Emergent patterns

Learning in community based settings is perhaps best achieved when the learners allow themselves to enter a meaningful relationship with the community. Student participants go so far as to suggest:

Coming from a private school I haven't seen a lot of what the community is, what the real community is…. I know that you have never seen a place like that in your life you know and you then realize of that community it's not what you think a community is, it's what they tell you a community is.

You can't get that from teaching, you have to be there and you have to see it and people have to come to you with that information (2012: A: 4).

It is within that encounter with the community outside of the formal university environment that the definition of community occurs. This community based learning experience allows the student to redefine the meaning of community through that relationship. This is reinforced by this extract from an academic partner:

I don't know how you teach it in a medical school. I mean it can only happen through engagement with community in one way or another, whether it's about, as a kind of minimum, bringing the community into the four walls of medical school but ideally it's about students getting out there (Acad 1).

Another student describes an appreciation for the more intimate space provided by being based in the community which allows one to see just how connected the sick patient is and the wider impact of that illness:

The web of interconnected relationships. If your patient comes to the hospital or she dies leaving behind children or leaving behind just a partner, you can't separate the patient from their community. (2012 C 4)

Another student expressed the difficulty in defining community specifically because *everyone is almost connected to everyone at the end of the day somehow (2013: E: 3).* This last comment echoes the aphorism 'umuntu ngumuntu ngabantu' (a person is a person through other people) (Molefe, 2011). This deeply rooted connectedness lies at the very heart of ubuntu. Acknowledging ubuntu as central allows a greater flexibility in engaging with cultural aspects of a society in which one works.

The cultural safety which is an important part of the relationships with community members appears to be best in the community based encounters. This student reported a colleague's experience:

> *The doctor during the family medicine block who actually knew the local traditional healers and actually had a better relationship with (his) patients because he was aware of his surroundings and what the patients did first and what they were exposed to and hence he had a better relationship and could change patient behaviour better because he understood patients as a whole and not just applied science and left it at that. (2013: F: 6)*

Linked to this deeper understanding of cultural context one of the provincial partners has inserted himself and his department into the traditional leadership structure and process:

> *The other (chiefs) all grew up in front of me. I knew their fathers... but, it's very important for doctors to... to know the communities that they serve. And I think... I've tried to instil it in managers, to say, if you're a new manager, within the first three months, you should have visited at least, every Kgosi*[24] *in your district. Go and tell him who you are, where you come from and what you do (Part 1).*

This extract also highlights the importance of the relationship with the community being a function of both the health administration and the health professional.

Strasser (2010) argues that the benefits accrued from community based learning in rural Canada have been enhanced by the emphasis placed on the relationships the community develops with the students through active hosting of students' learning activities and commitment to enhancing the students' learning experiences. Suchman (2006) characterises the social interactions in which all people engage as non-linear processes which allow new patterns to emerge almost continually. He refers to "iterative reciprocal interactions" which happen in the interaction between individuals and allows the self-organisation which is anticipated in complex adaptive systems (Suchman, 2006). It appears that this is what is happening when students enter community based learning. The relationships form a part of this iterative concept and students learn far more than the curriculum may have intended or that the student expected - *you then realize*

[24] Kgosi is a Sotho word for the chieftain within traditional tribal structure in this rural area of South Africa.

of that community, it's not what you think a community is, it's what they tell you a community is (2012:A:4).

If communities offer students the best way of defining what and who they are, then there is a challenge for communities in which students are educated to be the same for students. The notion of communities of practice with relationships which acknowledge the entry of the novice student for education and development is explored in the next proposal.

8.8 Proposal: Nurture relationship centred educating communities

8.8.1 Emergent patterns

Leach (2014) in his commentary on medical professionalism following the revised definition from the American Board of Medical Specialties employs a gardening metaphor in which he characterises roots as being the value system which a practitioner in training may have and the foliage as the technical knowhow which they are developing during their training relating to clinical expertise and research capabilities. Drawing on this metaphor, he describes a method for achieving professionalism of our graduates both from undergraduate or postgraduate programmes:

> *Learning the right way to break our hearts, to deepen reflective practice, to find time for solitude and for good conversations, and to nourish both our roots as well as our foliage both as individuals and as a profession requires that we recognise and create nourishing communities (Leach, 2014:700).*

The clinical environment with its role models in communities of knowledge and skills is an important site for the students to learn through experience both the foliage and root attributes they require for relevant practice after graduation (Finn et al., 2010). The student participants in this study expressed a range of experiences, often negative, in this regard:

> *At the moment we're chasing marks, and making sure that we pass (the examinations). He feels so helpless because you have to kind of bow*

down to the system as it is now so that you can get what you need to get out of medical school at the end of the day … and I have seen these guys, they struggle… everyone struggles and everyone sees an issue but no one… nothing gets to happen around here. I don't know why (2013: H: 7).

Students perceive their role in the ward based team as a strategic game of surviving the course. There appears to be little affirmation of their contribution to that team as was envisaged in the ideal communities of practice. Their experience of team work is limited by the threatening nature of the context:

Because we are in a very paternalistic setting and if you speak up, you'll get penalised and I think that's where... you'll get crushed (2013: J)

In contrast to this experience, a dialogue on transforming medical education in order to repair societies, argues that the development of long term relationships between communities, staff and students allows the students to unlock and harness some of their own humanity which they bring to the course (Hirsh and Worley, 2013). Hirsh et al. (2007) argue that continuity of supervision allows the development of an educating community which is characterised by a deeper level of intimacy between generations of clinicians allowing "iterative dialogue" based in the clinical practice context. They go on to suggest that this may enhance the "spirit of idealism" which must be a central element in the development of socially responsive and accountable practitioners (Hirsh et al., 2007).

It is in these educating communities where students can experience an educational intimacy which is characterised by participation in a team in which students and practitioners of varying disciplines may also engage. The idea of engaging other disciplines may extend the sense of team which students learn and experience. Currently, the interprofessional team is a limited concept and one in which the doctor appears to have considerable power:

There is still the power vested in one person (implied to be the doctor) with the most knowledge who is expected to be the leader even though there isn't a team. Because the team is not an equal team, you get a doctor and you get nurses and other people underneath. (Acad 7)

This reflection, by an academic, of the loosely structured relationships within the team which delivers care is the reality which students will currently experience, but it may also be the place for a demonstration of a more socially accountable and nurturing educational space. This is captured in the following extract:

> *When we are talking about relationships with the team and understanding that social accountability is not an individual effort by a doctor yes it's in a system but it's also ideally being part of a team (Acad 1).*

This concept of the team, based on relationships, becoming a site for the integration of social accountability into practice localized within the education community may need to reconstruct the notion of professionalism for the professions engaged in the team. It should be in these education communities that students should learn the behaviour which leads to a professional perspective. The next proposal examines this notion of professionalism and suggests that there is need for renewed emphasis on the relationships implied through professionalism rather than the pursuit of autonomy.

8.9 Proposal: Reconstruct professionalism for engaged citizenship

8.9.1 Emergent patterns

The American Board of Medical Specialties has reconstructed their view of medical professionalism as a way of life (Hafferty et al., 2012):

> *Medical professionalism is a belief system in which group members ("professionals") declare ("profess") to each other and the public the shared competency standards and ethical values they promise to uphold in their work and what the public and individual patients can and should expect from medical professionals. Core to both the profession's technical expertise and its promise of service is the view that members, working together, are committed to maintaining the standards and values that govern their practice and to monitoring each others' adherence to their standards on behalf of the public. (http://www.abms.org)*

This definition appears to elevate the definition of professionalism from the litany of attributes which have characterised the discourse on professionalism in medical education as it needs to be taught and assessed over the years (Creuss and Creuss, 2008; Cruess et al., 2004; Medical Professionalism Project, 2002). It comes as part of the ongoing attempts to define how the practice of medicine ought to be conducted especially in the light of the elevated value placed on the healing occupations in society which has been borne out in the data of this study and resonates with the literature (Collier, 2012).

This extract from an academic participant articulates the current tensions:

> *First it's for us to be aware as doctors that definitely you start off with a power imbalance and that you actually need to adopt a position of being an advocate for the patient. That's actually your role and your responsibility. That position wants you to behave ethically and responsibly according to certain norms and standards. So number one we need to be acutely aware of our powerful position with patients. Two, we need to inform; I think patient education (for autonomy) becomes important in the community. (Acad 10)*

This comment, echoed in other data in this study, reflects the multiple tensions which attempts to define professionalism have grappled with over the years. Central amongst these is the inherent power imbalance in the doctor – patient relationship, the responsibility to act as advocates for patients, the demand to act within certain codes of conduct and perhaps most importantly to respond directly to patients' needs often at the expense of personal interest (Hafferty et al., 2012).

The acknowledgement of the power held by the doctor in the healing relationship despite the historical "social contract" accorded to medical professionals means that doctors have a collective responsibility for the conduct of their peers (Hafferty et al., 2012; Creuss and Creuss, 2008). This responsibility may be enhanced through greater effectiveness of the professional associations for various disciplines within the medical community. An academic participant makes this call for these organisations to respond to the more social needs beyond the narrow financial self interests:

All I'm saying is our professional organizations. It's not just enough to organise your cheaper life insurance or negotiate with the medical aid schemes (health care funders) to pay steeper service tariffs. .... I think that as a group we could be doing so much more.... it's being conscious of where as doctors our power lies in that social fabric. So that we use our roles to, you know, leverage certain things which are morally and ethically correct. (Acad 9)

The leverage idea is an echo of the call to advocacy which emerged in the earlier extract and links to the following extract of the anticipated engagement by professional interest groupings:

Because of what I perceived to be the major shortcomings within the professional environment. They go about professional organisations not getting involved in the real issues that are happening in South Africa. And I do think that we still have lots to do from a professional perspective, not just in terms of the transformational component but the engagement, your true engagement (Acad 11).

This idea lies at the heart of the proposition that as we reconstruct professionalism we will see doctors engaged more powerfully as citizens. The manifestation of this citizen engagement has been heralded earlier in the Physician Charter's call for a professionalism to address three key principles – patient welfare, patient autonomy marked by collaboration between the individual patient and their doctor in order to achieve wellness and social justice which places the doctor firmly in the struggle for adequate distribution of the health care resource (Medical Professionalism Project, 2002).

Perhaps this comment best captures the ideal of professionalism:

Good professionalism is a habit, a habit that can be fostered by systematically answering three questions at the end of each day: how good a job did I do discerning and telling the truth, doing what was good for the patient, and making clinical judgements that were practical and wise(Leach, 2014:700).

The idea of habit reinforces the transformation of professionalism into a way of life as suggested at the beginning of this proposal. This finds resonance in the values of respect, dignity, solidarity, compassion and survival which Mbigi and Maree (2005) have crafted into the hand of ubuntu. The hand offers a stirring metaphor for the collective co-creation and interdependence of a reconstructed professionalism to take effect in a collective place such as the educational institution which produces the country's graduates. If this is the case then the students and the staff become integral dimensions of the community of professionals which advance social accountability. The next three proposals will discuss these dimensions as part of building such a community through the student community, the development of staff and the renewed commitment by the broader faculty community. The next proposal suggests that renewed attention be placed on the student community as a site for the co-creation of a renewed reality.

8.10 Proposal: Build a progressive and engaged student community

8.10.1 Emergent patterns

The impact of the educational environment which surrounds the formal curriculum is evident in the comments of academic partners who view themselves as being socially accountable in their current practice. This extract from an academic speaks of the experiences well beyond the confines of the curriculum in an international community based environment:

> *I had the very fortunate privilege of spending a year in Paraguay where I lived amongst the poor in a way that we couldn't do in South Africa at the time because of apartheid……but it wasn't the curriculum that did that, it was opportunities - peri-curricular opportunities (Acad 1).*

The peri-curricula idea is raised again in the following extract which suggests that student activities outside of the medical school were important for the development of social accountability.

We have spoken about Jackson Clinic[25], medical centre. The idea of having a clinic where before you start at the clinic everybody sits around - the community members, the health professional, those (students) who (have) volunteered at the time. You have a discussion of what happened in the last week, you then get on with your activities at the end of the day you come back again and say what the plan is for the next week ….

It was family influences. The environment I lived in was certainly a politically aware environment both in terms of home, in terms of (the) community I lived in and the social environment including school and university.... it was a time of turmoil, there were a lot of political activities at university and so the regular issues of solidarity with striking students (at other universities) (Acad 2).

This academic raised the importance of a family influence on the ability to interpret the signs of the times around him. The openness of the family space allowed the reflection of the turmoil of the apartheid days to turn into action on behalf of the communities which the student clinics served. The context of a South Africa with a clearly dichotomous society in which injustice prevailed led the following academic to experience a different way of looking at the world through his encounter with other students at the university – outside of the medical school – allowing the development of a social accountability framing of his work:

Growing up in this country, as a doctor, the injustice of the system was just, very, very much clearer. ... And engagement with the university environment, gives you an intellectual understanding of the things that you see and when you start to have an intellectual understanding of the things that you see it starts to give you a framework in which to reflect the things you see.....I was at university in the second half of the seventies, beginning of the eighties. And the university offered a very strong community of activists and people who were taking on the system. And so

[25] Jackson Drift was a student run community clinic for rural farm workers and residents of informal settlements in the Eikenhof area south of Johannesburg. Students volunteered to work at the clinic under supervision of local general practitioners.

it wasn't just medical school that was doing it, it was the university. (Acad 5)

From these expressions it became clearer that much of the development of relationship with communities, the engagement with a socio-political system as well as the development of intellectual framing of social conditions may happen for a student outside of the formal curriculum.

The expression from students in this regard is the immense pressure which is brought to bear on them through the assessment process which characterises medical curricula. The expression by student participants suggests that this peri-curricular activity has been a missed part of their student experience:

I had no time to do any of that (volunteer activity). The thought of putting that time aside to do that was just impossible in my mind. I was personally struggling academically so much. That was just a suicide thought (2013 J).

Participation in extracurricular activity is equated by this student to suicide in a desperate image of the extent to which the assessment process places a significant burden on students. This is reinforced by the feeling that stepping out of line may lead to negative consequences:

I believe in being an agent for change at the micro level but I'm not going to go and picket. Well, I used to... I was in a protest march back in the day when I was still quite idealistic... You don't want to antagonise the people who give you marks (2013 G6).

These extracts capture the pressures which engaging in extra curricula activities may bring to bear on the students' progress through medical school. In addition to this, the narrow focus on their academic performance which results may leave students unaware of their potential to act or unable to tap into their capacity to act:

I've been meeting with a group of students who are just desperate to get involved in something like social accountability. That is not happening for them, you know, in this program…Society is something that they've never

thought about. I mean there's this one young kid particularly that said "I never realized that this is part of what it actually meant to be a doctor - to think and have these conversations. I never even thought that this was part of medicine. So the point is, is that it is actually off limits for medicine now. It's something you do in your own time. It's something that is political; it will compromise your neutrality (Acad 9).

The medical school has some responsibility to create the space for students' involvement outside of the curriculum and this involvement may challenge the sense of neutrality especially if it advocates on behalf of those who exist at society's margins.

All doctors should be fully engaged in society's wellness ... these are the stated goals that we want people to (develop). We need to engage with our students. It's interesting when you look at the medical student for instance, or any of the health care students, the health care sciences students, there's this subset of individuals who want to be involved in the broader picture, who come into the medical school and study to become a doctor. It's the kids that get involved in the Student Representative Council[6], in your Medical Student's Councils[26] *and now in some of the societies like your Surgical Students Society or the Rural Health Society, those individuals see this already, I mean we need to get the other side. Unfortunately it's the majority who don't immediately get involved, they'll participate but they are not involved (Acad 11).*

The case must clearly be made for the development of student capacities outside of the formal curriculum. There are precedents in international settings where the development of student clubs around particularly rural health have created benefit (Worley and Murray, 2011; Rourke, 2006).

An increasingly engaged student community will require a different pedagogical and professional approach from staff within the medical school. This aspect will

[26] Both these student councils are student governance structures for the university more broadly and then for students in the medical degree.

need to be made more explicit in the methodology of the faculty development. This concept is developed further in the next proposal.

8.11 Proposal: Create faculty development for socially accountable role modelling

8.11.1 Emergent patterns

There is a recurrent echo throughout this data, from the community's expressed expectation of what students should be taught, to the idea from students that their teachers have not always shown them how to be good. An animated statement is made by an academic partner in the following extract which starts off with a reflection on the importance of the individual patient-doctor relationship but also suggests the role of the teacher in broadening the perspective of the student:

> *But it doesn't stop there (with the patient-doctor relationship) and I think the students do struggle and sometimes it's because maybe as teachers, we're not talking about the bigger picture and making them aware that they can actually alter... influence... events to the benefit of a community rather than an individual by their actions. So, I think that's what's missing and I think sometimes it's easy to focus on the individual (Acad 4).*

This academic goes on to describe more deeply what is needed from the teachers:

> *The broader concept of teaching students is trying to enthuse them about all these different aspects. The medical technical aspects but these other... the social accountability, you know, the humanism of medicine is absolutely necessary. So we could influence students to a much greater extent. We may not win with everybody, but I think we could win with the majority (Acad 4).*

The idea of winning students over to a broader view of the social condition of the patient means looking at the patient's clinical condition and seeing beyond the pathogenesis to their context:

Come back to the role-models. There are opportunities that come up in the bedside teaching environment... when you're teaching them and something crops up... and if one can encourage the teachers and the role-models to explore that little thing a bit more... that's a wonderful time because it's a very spontaneous thing that would have come up in the context of... say a bedside teaching round. A little question, maybe from the students, and that can lead to a ten minute interaction on a particular topic which is a bit beyond just the... the nitty gritty of medicine. Those informal teaching moments are so important (Acad 4).

This goal for teachers is something that must be encouraged in our teachers who then become a gateway for the students' enriched experience of the patient encounter.

Dharamsi et al. (2011:1111) suggest five ways to develop behaviours which should be modelled in the professionals who receive students into their practice domains for learning to enhance those students' development of social accountability. These are:

- *Identify and become involved in advocacy issues related to your discipline;*
- *Apply evidence based prevention and health promotion initiatives at the patient, community and population levels;*
- *Identify and respond to factors outside the clinical encounters that influence health;*
- *Examine and respond to factors that result in barriers to care;*
- *Take a scholarly approach to advocacy by encouraging and/or participating in research that contributes to improved understandings*

All of these interventions will need to form part of the faculty development of both registrars and consultants in the education and health systems. Many of these statements are also supported by expressions emergent in the data of this study.

Couper et al. (2013), writing in their WHO policy brief on faculty development suggest a wide range of competencies in which teachers should be prepared but highlight the need to assure their competence in adapting curricula to context and

matching these with the populations which they serve. They also confirm the notion of preparing those in training for appropriate roles as teachers (Couper et al., 2013).

8.12 Proposal: Commit the faculty community to becoming change agents in defined communities

8.12.1 Emergent patterns

Becoming a change agent has become the currency of the discourse stimulated by the Lancet Commission report of 2010 (Frenk et al., 2010). The commission is clear that the educational institutions have a responsibility to graduate these change agents, but is silent regarding the responsibility to address those faculty members who may represent resistance to this transformative idea or, indeed, are non- committal (Frenk et al., 2010). While this report and the evaluation frameworks currently being recommended suggest that the staff in an institution should become reflective of the demographic of marginalisation, there is still very little in the literature which suggests that any particular value is being placed on who is selected for the job of teaching prospective change agents (Frenk et al., 2010; The Training for Health Equity Network, 2011; Couper et al., 2013). It appears that faculty development as described earlier may be an important commitment made by the faculty as a whole to move in the direction towards social accountability. Faculty development will be given more substance if the faculty makes clear its *conceptualisation* of the way to move forward, adopts *production* processes that transform and ensures the *usability* of both their graduates and their teachers in meeting the needs of the reference community the faculty chooses to serve (Boelen and Woollard, 2011; Woollard and Boelen, 2012; Woollard, 2006).

The participants in this study have been vocal in their expectation of the university:

> *We should also blame the Medical Schools because we can see the challenges that we are getting in terms of health in South Africa but we never sit down and say "how can we like (help out)?" I am referring to people who studied medicine and have knowledge in terms of the determinants of diseases that are working in for example the Department*

of Public Health, the Public services, people who are working in the mines etc, but the doctors who understand the effect of this particular thing on the community. (2013 E)

This student participant blames the medical school for its inability to work with the government structures in improving the delivery of health care. But still another participant has recognised some of the inputs through the curriculum which have highlighted the socio-political conversation represented in the country's history:

(A professor) was talking about the legacy of apartheid on medical schools. And he was also talking about the statue outside[27]*. Some of us have a more political nature and some of us don't. No one is saying you must be a politician but you do have to understand the make-up of your country... and you do have to be more aware and us going to Bara, and treating them and having compassion, is good. You are a good person. No one is saying whether you're a good person or a bad person but I think it (the curriculum) doesn't teach us enough about where these people actually come from. And I am using the example of myself because I am not from a situation where most South Africans are from. And I really feel like they side-step teaching us really in-depth about that, it is almost they don't want to make any one the "bad person". They don't want to point any political fingers or they don't want to discuss maybe racism, tribalism or something like that occurs. It's almost like they pick us up and now we are supposed to form a new class of people "Doctors". You know, we no longer exist as part of all this (background) (2013:E:2)*

This participant raises a series of challenges which the university may need to address in the development of a culture which nurtures the change agents desired. The introduction of the concept of doctors forming a different class of people may need to form part of the reflections for both professionalism and the building of a renewed faculty community.

[27] A statue has been erected outside the health sciences faculty building which represents reconciliation. This followed a faculty based Internal Reconciliation Commission process in the spirit of the national Truth and Reconciliation which dealt with discrimination experienced in the medical school under an apartheid regime.

The selection of a specific reference population may assist in the creation of measurements and markers for the achievement of a socially accountable ideal. The idea of a community in which a university hospital is based not acknowledging the link between the hospitals and the university presents a challenge to how the urban communities of Johannesburg perceive the university. This participant from Alexandra believes the links should be more explicit:

> *I do believe that Wits needs to do something to Alexandra, because as far as I am concerned, Alexandra falls within the University's sphere of influence because it is the nearest University next to Alexandra. (Urban 3)*

While the university is active in many of the communities, these actions may not be apparent to all members of the community. In fact, communities perceived the relationships as only benefiting the learning of the students:

> *We don't concentrate on them (the students). The students come and they are walking with doctors and nurses... they can make a difference for their marks but to the people, because they are not professional yet, they are just considered as helpers or assistants (Urban 3).*

This statement reflects the challenges of community based engagement which have been raised elsewhere (Alperstein, 2007; Strasser, 2010). The presence of students is often seen as facilitating the service provision at the health facilities but it is not perceived as a contribution from the university as an institution.

8.13 Summary

This chapter has immersed the concept of social accountability in the lived experience expressed by participants in this study. The relationships implicit in the data were framed in a discussion about ubuntu – first expressed as an expectation by a community participant. Through this ubuntu or African humanist perspective, our interconnectedness as members of a community was highlighted and relationships emerged as the unit of currency for a discourse on social accountability. This was framed as a complex adaptive system which allowed concurrent reflection on the ten propositions put forward in the framework for the advancement of social accountability. The emergence of these ten proposals was

enabled by ideas describing community concepts, student expressions and the road to health which reflect the partners' perspectives. Despite the propositions being presented in a sequential order for purposes of this discussion, there is no anticipated hierarchy. This lack of a priority hierarchy was noted strongly by the panelists in the national seminar. They suggested that the model allowed anyone who was interested in using it for the practical advancement of social accountability could start with any of the proposals without being compromised. In particular, it enabled institutions to embark on particular proposals which had greatest opportunity for success in their context.

However, these proposals relate to each other as opposite ends of a series of pairs. If one sees the social determinants of health as a key starting point, there must be an equal commitment to developing sound patient – doctor relationships. When one realigns the curriculum with the health priorities of a community, the implicit supporting action must be the development of faculty development which ensures teachers are attuned to becoming socially accountable role models. The flipside of education within communities is the emergence of engaged student communities open to relationships with communities who may be different to them. In order to empower communities, the profession has to reconstruct its own ideas of power towards different levels of engagement. And finally, the building of education communities in which relations of the learners and the teacher are valued have the end result of a faculty community which is made up of agents of change.

These proposals are best regarded as offering a way of *seeing* within a context (conceptualisation), *focussing* on the relationships of learning and teaching (production) and *choosing* a different way of being (usability). Indeed all of these statements may themselves be regarded as semi-autonomous agents which are interconnected and dependent on each other to allow their self- organisation which is characteristic of complex adaptive systems. This chapter described the people engaged in advancing social accountability, the processes which may be needed to facilitate this advance and, most importantly, the promise that these relationships may hold for the health of all people. The next chapter will take these

ideas forward and summarise the impact they have for the teaching and learning environment of doctors and perhaps all health professionals.

Chapter 9:
Final Reflections and a Road Map for the Future

9 Final reflections and a road map for the future

9.1 Introduction

This thesis has described the process through which many previously silent stakeholders have expressed themselves on the issue of social accountability. From the rural villages of Mpumalanga to urban settlements in Gauteng, South African community members have contributed an answer to the questions facing doctors in their pursuit of socially accountable practice in the 21st century. The community, while never clearly articulating a definition of social accountability couched their concepts of relationship in an ubuntu framework. These expressions have been echoed through the engagements with final year medical students close to their graduation. Most of these aspirant doctors enter their training with great idealism but they have been constantly faced with the challenge of becoming desensitized and disillusioned. Despite this, the students' articulation of social accountability resonates with the international community's calls for the education of doctors to match the needs of communities which they are called to serve (Boelen and Heck, 1995). Part of the learning of this spirit of accountability comes from their teachers through role modeling in the individual relationships with patients at the bedside or in the clinic. This view is taken up by both the academic and administrative partners who share responsibility for the education of doctors in multiple educational contexts. While the administrative partners were more vocal about what should happen in training, the academic partners expressed an aspiration that students would graduate as more than the sum of the knowledge which they learnt while at university and accepted their responsibility for assisting the students to achieve the competency required to see a world beyond the immediate consultation.

Through the models which emerged with each of the groups of people, these stakeholders have given voice to the advancement of social accountability in the ten propositions which converged in the framework described in the previous chapter. The framework defines the movement towards greater social accountability in three domains. In a domain reflective of greater awareness of context, the framework highlights the importance of empowering communities to address the social determinants of health in partnership and the need for these to be aligned in medical curricula. The building of meaningful relationships forms the heart of the framework. Relationships are strengthened by the deepening of trust between doctors and their patients, whilst also enriching the learning which may be occurring within the community. The call for a nurturing environment within education communities means a reconstruction of the notions of professionalism as citizenship. Finally, the framework uses this renewed professionalism as the basis for faculty development, the growth of an engaged student community and the conceptualization of the commitments within the broader faculty establishment.

The framework goes some way to filling the gap identified at the beginning of this study – the silence of the stakeholders in the social accountability discourse. This chapter proposes a translation through which the framework may vivify the movement towards a deepening accountability to the society in which doctors are called to serve.

9.2 Making a promise

The findings of this study may best be articulated as the dynamic interaction between people, the processes which bound their interaction and the promise implicit in the relationships between these ideas and the systems which surround them (See Figure 9.1).

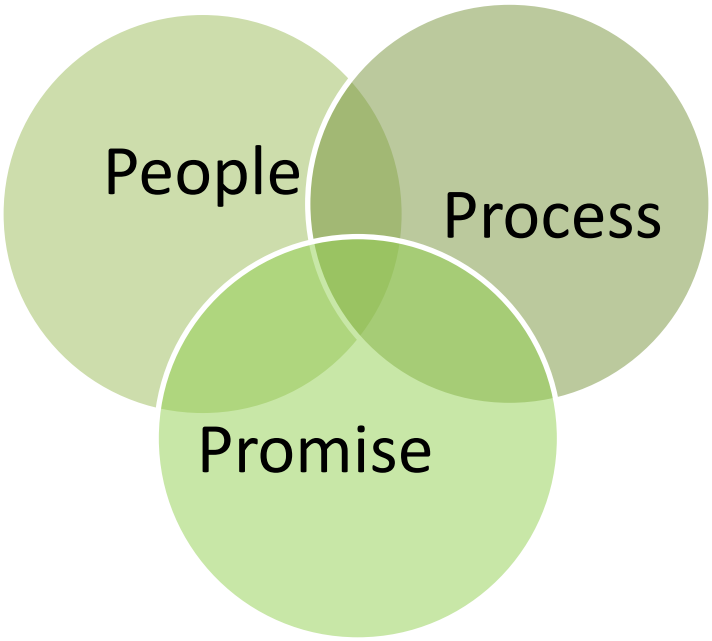


Figure 9.1: Interacting elements in the advancement of social accountability

9.2.1 The people

This study has heard the voices of communities in relation to their doctors, of medical students in relation to their patients, their colleagues and their teachers and of the partners in education in relation to their communities and the systems in which they work. The basis of these relations has opportunities for symbiotic development of engaged professionals (Prideaux et al., 2007). Worley et al. (2006) provided empirical evidence of this relatedness between all the actors in a developmental learning environment. The four major relationships which they describe as being a part of the student experience are that between the health service and university research, the community and government, the expectations of the profession and what they hold as personal principle as well as the patients' relationship with the students (Worley et al., 2006). These relationships and their becoming more explicit for students allowed their learning experience to be enhanced. Through these community based experiences, the authors have demonstrated that through relationships there is a development of both the learners and their relationships with others (Worley et al., 2006). Taylor (2000) has included the idea of movement towards increased connection with others as a

central feature of the developmental intention of teaching in a transformative paradigm. It is the individual learner's relationships with others which allows the development of an understanding that they are part of something bigger (Taylor, 2000).

This notion of being part of something bigger appears to be stifled to some extent amongst both communities and the students by the negative impact of the power relationships which they experience in the health and education environment respectively. Despite these tensions, these relationships remain a central part of the students' learning which is a dialogical process. In his book, *A Post-Modern Perspective on Curriculum*, Doll asserts that the context of the dialogue is important:

> *Here lies the basis for the dialogue, and it is through this dialogue within a caring and critical community that methods, procedures and values are developed into life experiences (Doll, 1993:168).*

This extract suggests that learning through life experiences is a central consequence of the relationships within a community, both the educating community and the geographical community.

There are various players in both the delivery of health care and in the delivery of health professions education and the development and enhancement of the relationships between these two systems increases the chances of graduating professionals who are engaged in the world (Frenk et al., 2010).

Responding to this need, the challenge is to develop learning systems which acknowledge that the curriculum is one process of a complex adaptive system (Doll and Trueit, 2010; Mennin, 2010; Doll, 1993).

9.2.2 The process

The reflections offered by participants in this study suggest that while the current curricular processes may produce a technically adequate product, there may be room to improve the usability of this product for a healthier future (Woollard and Boelen, 2012; Woollard, 2006). The community's call for the inclusion of ubuntu in

curricula is matched by students' perceptions of good role models in the caring for and respect of patients. This may come as a consequence of the focus on a quantitative assessment scale which may drive students to learn in ways which undermine relationship.

This tension is based on the cognitive load with which students may have to engage. Young et al. (2014) construct the cognitive load as being intrinsic, extraneous or germane. The intrinsic load refers to the knowledge that is required for the task and may be characterised as the factual content which may have to be mastered in a curriculum and the extraneous load which is related to instructional design and curricula format which add an additional level of complexity to the learning of tasks. The authors suggest that the germane load is the amount of effort that is required to think about the learning, in contrast to doing the task. These three dimensions of load are in a constant relationship and tension, with an increase in one area causing a compensatory decrease in the other (Young et al., 2014). In the building of relational learning suggested earlier there may be need to be a defense of the space for the germane load to be engaged with sufficiently. These loads are a part of all learning in a similar way to the way in which informative, formative and transformative learning ages have characterised health professions education (Frenk et al., 2010).

While one may be tempted to characterise the reflections in the Lancet Report of 2010 regarding learning as passing from informative (factual memorization), to formative (valuing professional identity) through to transformative learning dimensions, it may provide a better understanding of the complexity of learning in the health sciences to accept that all these approaches are part of all professional learning experiences in much the same way as the three dimensions of cognitive load are in relation (Frenk et al., 2010). The convergence of these two approaches to what needs to be learnt by graduates or taught by teachers is represented in Figure 9.2.

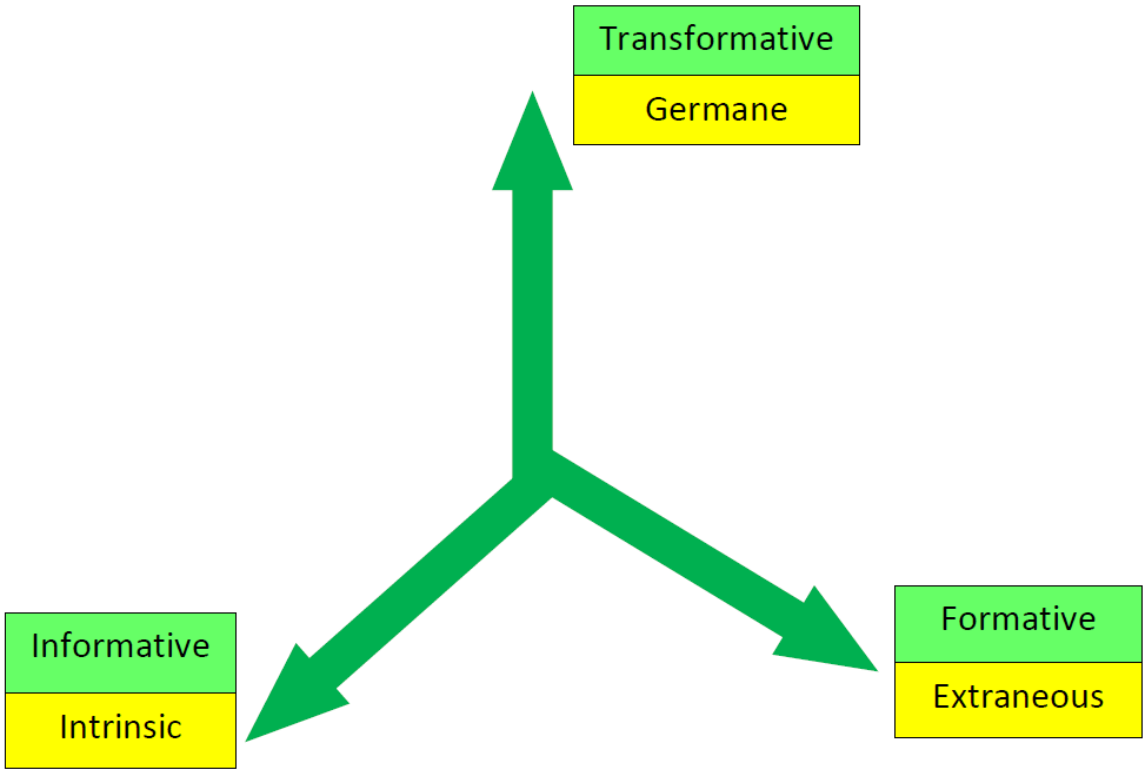


Figure 9.2: The convergence between dimensions of cognitive load and the nature of learning developed from current literature (Frenk et al., 2010; Young et al., 2014; Hugo, 2013)

I propose through this graphic that the ongoing relationships between intrinsic and extraneous load must be balanced by the creation of space and community in which to engage with the germane load. This is the same when reflecting on the different types of learning discussed in the Lancet Report of 2010 (Hugo, 2013; Frenk et al., 2010; Young et al., 2014). The central achievement is a curriculum where the germane load has precedence and the transformative learning domain is central.

The four R's suggested by Doll (1993) may be a framework in which to design a curriculum which takes heed of the expressions of participants of the need to build relationships based on ubuntu with community and within the education context, deepen reflection with guidance by mentors, use different environments for learning and the aspiration for graduates to see a broader dimension of the illness script of their individual patient.

Doll (1993) suggests that a post modern curriculum be framed by the following four R's:

- Richness which implies a great variety of possible end points to learning through cognitive dissonances;
- Recursion which is the deepening of reflection when the end of one experience provides the starting point for a new experience;
- Relations which speak to both the cultural (context in which a curriculum is situated) and the pedagogical (the connectedness of events and processes) relationships within a curriculum ; and
- Rigor which demands a continuous search for new ways of knowing and the recognition of emergent patterns.

Mennin (2010) presents the above framework as an important grid for the development of complex curricula. He argues that learning needs to become relationship centred so that there is a sense of the co-responsibility between the teacher and the student for the evolution of knowing (Mennin, 2010)

Knowing forms a part of changing the graduates world view as proposed through transformative learning (Frenk et al., 2010; Mezirow, 2000). Transformative curricula must allow learners the opportunities to become aware of their understandings of the world, enable critical reflection of these understandings and facilitate their taking action in response to these reflections (Mezirow, 2000). It is this action which forms a central part of the promise which the education of health professions makes to the society in which this education occurs.

9.2.3 The promise

The promise of improved health care for all is held in the interaction between those who deliver care to the people and the people's responsibility through which they are enabled to take care of themselves. The Alma Ata declaration was an early attempt to place the power for the advancement of health in the hands of the people (World Health Organisation, 1978). The Millennium Development goals represented a convergence of social development with the goals of achieving milestones in health care delivery (United Nations Development Programme,

2000). The South African National Development Plan seeks to improve access to health through universal coverage (National Planning Commission, 2011).

All of these statements of intent have the fundamental premise of making a difference. It is this difference which THEnet's Evaluation Framework for Socially

Accountable Health Professional Education seeks to evaluate in the measurement of social accountability in health education institutions (The Training for Health Equity Network, 2011). The framework gauges the delivery on the promise through a reflection on where graduates practise, the impact of the university on the health of the reference population, how the university has impacted policy for sustainable development and whether this has happened in partnership with other schools.

9.3 The road ahead

The implication of this study is that in the South African medical education environment three groups of stakeholders have articulated their aspirations for social accountability. The proposal of a unifying framework for the advancement of social accountability defines more clearly the paradigms in which the work must be done in education practice to achieve these aspirations.

In conclusion, this study recommends the following signposts:

- Acknowledge the commitment to serve a reference community
- Build relationships with that community for their empowerment
- Create a learning environment which nurtures a spirit of engagement
- Demonstrate through role modelling the rigor of learning which is always exploring new ways of knowing and serving
- Engage with the many partner systems in the complexity of health.

9.4 Summary

This chapter has reflected on the outcomes of this study as regards the frameworks emerging from all the participating groups. In characterising the

outcome as the relationship between the people who interact and relate to each other, the processes through which this happens and the promise that is implicit in a progressive education environment, this chapter offers a broader perspective of what this study means as we commit to the advancement of social accountability. This chapter concludes with five actions which will embolden this movement – Acknowledge; Build; Create; Develop; Engage.

References

Alperstein M. (2007) Getting closer to the Community Voice in Curriculum Development: an Exploration of the Possibilities. *Education as Change* 11: 59-67.

Arnstein SR. (1969) A Ladder of Citizen Participation. *Journal of the American Institute of Planners* 33: 216-224.

Ashford LS, Gwatkin DR and Yazbeck AS. (2005) Designing Health and Population Programs to reach the poor. *Population Reference Bureau.* Washington

Barker D. (2004) The Scholarship of Engagement: a taxonomy of five emerging practices. *Journal of Higher Education Outreach and Engagement* 9: 123 - 137.

Barrett CB, Carter MR and Little PD. (2006) Understanding and Reducing Persistent Poverty in Africa: Introduction to a special issue. *Journal of Development Studies* 42: 167-177.

Belenky M and Stanton A. (2000) Inequality, Development, and Connected Knowing. In: Mezirow J (ed) *Learning as transformation: critical perspectives on a theory in progress.* First ed. San Francisco,CA: Jossey-Bass, 73-102.

Bem C. (2010) Social governance: a necessary third pillar of healthcare governance. *Journal of the Royal Society of Medicine* 103: 475-477.

Berry L. (2011) Creating Community: Strengthening Education and Practice Partnerships through Communities of Practice. *International Journal of Nursing Education Scholarship* 8:1. DOI: 10.2202/1548-923X.2180.

Boelen C. (1994) Frontline doctors of tomorrow. *World Health* 47: 4-5.

Boelen C and Heck JE. (1995) *Defining and measuring the social accountability of medical schools*. Available at: http://whqlibdoc.who.int/hq/1995/WHO_HRH_95.7.pdf. Accessed 30 July 2012

Boelen C and Woollard B. (2009) Social Accountability and accreditation: a new frontier for educational institutions. *Medical Education* 43: 887-894.

Boelen C and Woollard R. (2011) Social accountability: The extra leap to excellence for educational institutions. *Medical Teacher* 33: 614-619.

Braun V and Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3: 77-101.

Britten N. (1995) Qualitative interviews in medical research. *British Medical Journal* 311: 251 - 253.

Bryant A and Charmaz K. (2007) Introduction: Grounded theory research: methods and practices. In: Bryant A and Charmaz K (eds) *The SAGE Handbook of Grounded Theory.* First ed. London: SAGE Publishers.

Celletti F, Reynolds TA, Wright A, Stoertz A and Dayrit M. (2011) Educating a New Generation of Doctors to Improve the Health of Populations in Low- and Middle-Income Countries. *PLoS Medicine* 8: e1001108.

Chapman T. (2014) Occupying the divide: Investigating a justice-based approach to urban design in the former western areas of Johannesburg. *Built Environment.* Johannesburg: University of the Witwatersrand, 83.

Charmaz K. (2000) Grounded Theory objectivist and constructivist methods. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research.* Second ed. Thousand Oaks, California: SAGE Publciations, 1064.

Charmaz K. (2010) *Constructing Grounded Theory,* London,UK: Sage Publications Inc.

Chinn PL and Kramer MK. (2008) *Integrated Theory and Knowledge Development in Nursing,* St Louis, Missouri: Mosby Elsevier.

Chopra M, Daviaud E, Pattinson R, Fonn S and J.E L. (2009) Saving the lives of South Africa's mothers, babies, and children: can the health system deliver? *Lancet* 374: 835-846.

Chopra M, Lawn J, Sanders D, Barron P, Abdool Karim SS, Bradshaw D, Jewkes R, Abdool Karim Q, Fisher AJ, Mayosi BM, Tollman SM, Churchyard GJ and Coovadia H. (2009) Achieving the health Millenium Development Goals for South Africa: challenges and priorities. *Lancet* 374: 1023-1031.

Collier R. (2012) Professionalism: the historical contract. *Canadian Medical Association Journal* 184: 1233-1234.

Coovadia H, Jewkes R, Barron P, Sanders P and McIntyre D. (2009) The health and health systems of South Africa: historical roots of current public health challenges. *Lancet* 374: 817-834.

Corbin J and Strauss A. (2008) *Basics of Qualitative Research Techniques and procedures for developing grounded theory,* Thousand Oaks, California: Sage Publishers.

Couper I, Sen Gupta T, McInerney P, Larkins S and Evans R. (2013) Transforming and Scaling Up Health Professional Education and Training. Policy Brief on Faculty Development. Geneva,Switzerland: World Health Organization.

Creswell JW. (2003) *Research Design Qualitative, Quantitative and Mixed Methods approaches,* Thousand Oaks, California: Sage Publications.

Creswell JW. (2007) *Qualitative Inquiry and Research Design: choosing among five approaches,* Thousand Oaks, California: Sage Publishers.

Creswell JW. (2014) *Research Design: qualitative, quantitative and mixed methods approaches,* Thousand Oaks, California: SAGE publications.

Cruess RL and Cruess SR. (2008) Expectations and Obligations: Professsionalism and Medicine's Social Contract with society. *Perspectives in Biology and Medicine* 51: 579-598.

Cruess SR, Johnston S and Cruess RL. (2004) "Profession": a working definition for medical educators. *Teaching and Learning in Medicine* 16: 74-76.

Commission on Social Determinants of Health. (2008) Closing the gap in a generation: health equity through action on social determinants of health. *Final Report of the Commission on Soical Determinants of Health.* Geneva: World Health Organization.

Dannhauser P. (2008) Representation of Coloured identity in selected visual texts about Westbury, Johannesburg. *Dramatic Art.* Johannesburg: University of the Witwatersrand.

de Souza R. (2011) Local Perspectives on Empowerment and Responsibility in the New Public Health. *Health Communication* 26: 25-36.

Dharamsi S, Espinoza N, Cramer C, Amin M, Bainbridge L and Poole G. (2010a) Nurturing social responsibility through community service-learning: Lessons learned from a pilot project. *Medical Teacher* 32: 905-911.

Dharamsi S, Ho A, Spadafora S and Woollard R. (2011) The Physician as Health Advocate - Translating the quest for social responsibility into medical education and practice. *Academic Medicine* 86: 1108-1113.

Dharamsi S, Richards M, Louie D, Murray D, Berland A, Whitfield M and Scott I. (2010b) Enhancing medical students' conceptions of the CanMEDS Health Advocate Role through international service-learning and critical reflection: A phenomenological study. *Medical Teacher* 32: 977-982.

DiCicco-Bloom B and Crabtree BF. (2006) The qualitative research interview. *Medical Education* 40: 314-321.

Doll WE. (1993) *A post-modern perspective on curriculum,* New York: Teachers College Press.

Doll WE and Trueit D. (2010) Complexity and the health care professions. *Journal of Evaluation in Clinical Practice* 16: 841-848.

Fawcett J. (2005) Criteria for Evaluation of Theory. *Nursing Science Quarterly* 18: 131-135.

Finn G, Garner J and Sawdon M. (2010) 'You're judged all the time!' Students' views on professionalism: a multicentre study. *Medical Education* 44: 814-825.

Flexner A. (1910) Medical Education in the United States and Canada. New York City: The Carnegie Foundation for the Advancement of teaching, 364.

Frank JR. (2005) The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College 0f Physicians and Surgeons of Canada.

Frank JR and Danoff D. (2007) The CanMEDS initiative: implementing an outcomes-based framework of physician competencies. *Medical Teacher* 29: 642-647.

Freire P. (1996) *Pedagogy of the Oppressed,* London, England: Penguin Group.

Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, Fineberg H, Garcia P, Ke Y, Kelley P, Kistnasamy B, Meleis A, Naylor D, Pablos-Mendez A, Reddy S, Scrimshaw S, Sepulveda J, Serwadda D and Zurayk H. (2010) Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet* 376: 1923-1958.

GCSA. (2010) *Global Consensus for Social Accountability of Medical Schools*. Available at: http://healthsocialaccountability.sites.olt.ubc.ca/files/2011/06/11-06-07-GCSA-English-pdf-style.pdf. Accessed 20 May 2014

Glouberman S and Zimmerman B. (2002) Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like? *Discussion Paper 8.* Commision on the Future of Health Care in Canada.

Green, L. W. and Kreuter, M. W. 2005. *Health programme planning: an educational and ecological approach,* New York, McGraw Hill

Habib A. (2013) *South Africa's Suspended Revolution,* Johannesburg, South Africa: Wits University Press.

Hafferty F, Papadakis M, Sullivan W and Wynia M. (2012) *ABMS Professionalism Definition*. Available at: http://www.abms.org/News_and_Events/Media_Newsroom/features/feature_ABMS_Professionalism_Definition_LongForm_abms.org_040413.aspx. Accessed 16 May 2014

Harris B, Eyles J, Penn-Kekana L, Fried J, Nyathela H, Thomas L and Goudge J. (2013) Bringing Justice to Unacceptable Health Care Services? Street-Level Reflections from Urban South Africa. *International Journal of Transitional Justice*, 1 -21. DOI: 10.1093/ijtj/ijt028

Harris B, Eyles J, Penn-Kekana L, Thomas L and Goudge J. (2014) Adverse or acceptable: negotiating access to a post-apartheid health care contract. *Globalization and Health* 10: 35.

Harris B, Goudge J, Ataguba J, McIntyre D, Nxumalo N, Jikwana S and Chersich M. (2011) Inequities in access to health care in South Africa. *J Public Health Policy* 32: S102 - S123.

Harry B, Sturges KM and Klinger JK. (2005) Mapping the Process: an exemplar of process and challenge in grounded theory analysis. *Educational Researcher* 34: 3-13.

Hirsh D, Ogur B, Thibault G and Cox M. (2007) “Continuity” as an Organizing Principle for Clinical Education Reform. *New England Journal of Medicine* 356: 858-866.

Hirsh D and Worley P. (2013) Better learning, better doctors, better community: how transforming clinical education can help repair society. *Medical Education* 47: 942-949.

Huber M. (2010) Invitational Conference 'Is health a state or an ability? Towards a dynamic concept of health'. Health Council of the Netherlands.

Huber M, Knottnerus J, Green L, van der Horst H, Jadad A, Kromhout D, Leonard B, Lorig K, Loureiro M, van der Meer J, Schnabel P, Smith R, van Weel C and Smid H. (2011) How should we define health? *British Medical Journal* 343: d4163.

Hugo W. (2013) *Cracking the Code to Educational Analysis,* Cape Town: Pearson Education South Africa.

Kawachi I and Kennedy BP. (1997) Socioeconomic Determinants of Health: Health and Social Cohesion: Why Care about Income Inequality? *BMJ: British Medical Journal* 314: 1037-1040.

Khoza R. (2011) *Attuned leadership: Africn Humanism as compass,* Johannesburg, SA: Penguin Books.

Khoza V and du Toit H. (2011) The Batho Pele Principles in the health service. *Professional Nursing Today* 15: 8-11.

Kitzinger J. (1995) Qualitative Research: Introducing focus groups. *BMJ* 311: 299-302.

Kruss G. (2012) Reconceptualising engagement: a conceptual framework for analysing university interaction with external social partners. *South African Review of Sociology* 43:2, 5 – 26, DOI: 10.1080/21528586.2012.694240

Kwizera EN and Iputo JE. (2011) Addressing social responsibility in medical education: The African way. *Medical Teacher* 33: 649-653.

Laverack G. (2006) Improving health outcomes through community empowerment: a review of the literature. *Journal of Health Population and Nutrition* 24: 113-120.

Leach DC. (2014) Transcendent Professionalism: Keeping Promises and Living the Questions. *Academic Medicine* 89: 00-00.

Madriz E. (2000) Focus Groups in feminist research. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research.* Second ed. Thousand Oaks, California: SAGE Publications, 1064.

Malena C, Forster R and Singh J. (2004) *Social Accountability An introduction to the concept and emerging practice*. Available at: http://siteresources.worldbank.org/INTPCENG/214578-1116499844371/20524122/310420PAPER0So1ity0SDP0Civic0no1076.pdf. Accessed 18 March 2013.

Mann K, Gordon J and MacLeod A. (2009) Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Science Education* 14: 595-621.

Markowitz GE and Rosner DK. (1973) Doctors in Crisis: a study of the use of medical education reform to establish modern prfoessional elitism in medicine. *American Quaterly* 25: 83-107.

Mayosi BM, Lawn JE, van Niekerk A, Bradshaw D, Abdool Karim SS and Coovadia H. (2012) Health in South Africa: changes and challenges since 2009. *Lancet* 380: 2029-2043.

Mbigi L and Maree J. (2005) *Ubuntu: The Spirit of African Transfromation Management,* Randburg, SA: Knowres Publishing.

McKnight JP. (1997) A 21st-century Map for Healthy Communities and Families. *Families in Society*: 117-127.

Medical Professionalism Project. (2002) Medical Professionalism in the New Millennium: A Physician Charter. *Annals of Internal Medicine* 136: 243.

Meili R, Fuller D and Lydiate J. (2011) Teaching social accountability by making the links: Qualitative evaluation of student experiences in a service-learning project. *Medical Teacher* 33: 659-666.

Mennin S. (2010) Self-organisation, integration and curriculum in the complex world of medical education. *Medical Education* 44: 20-30.

Mertens DM. (2007) Transformative Paradigm: Mixed Methods and Social Justice. *Journal of Mixed Methods Research* 1: 212-225.

Mertens DM. (2010) Transformative Mixed Methods research. *Qualitative Inquiry* 16: 469 -474.

Mezirow J. (2000) Learning to Think Like an Adult - core concepts of transformation theory. In: Jack Mezirow and Associates (ed) *Learning as Transformation.* 1 ed. San Francisco, United States: Jossey-Bass, 3 - 33.

Michaels D, Naidu C, Reid S, Burch V, Neusy A-J, Mfenyana K, Veres N and Green-Thompson L. (2013) Developing an approach and methodology to

assess Social Accountability of Health Sciences Faculties in South Africa. Cape Town. (Unpublished report)

Molefe M. (2011) What can the socio-political ethic of ubuntu contribute to contemporary conceptions of "development"? *Philosophy.* Johannesburg, SA: University of the Witwatersrand.

Moral Regeneration Movement. (2001) *Charter of Positive Values*. Available at: http://www.presidency.gov.za/pebble.asp?relid=186&t=79. Accessed 3 December 2013

Mullan P, Williams J, Malani P, Riba P, Haig A, Perry J, Kolars J, Mangrulkar R and Williams B. (2014) Promoting medical students' reflection on competencies to advance a global health equities curriculum. *BMC Med Educ* 14: 91.

National Planning Commission. (2011) *National Development Plan: Vision fo 2030,* Pretoria: Department: The Presidency.

Parse RR. (2005) Parse's Criteria for Evaluation of theory with a comparison of Fawcett's and Parse's approaches. *Nursing Science Quarterly* 18: 135-137.

Pauli HG, White KL and McWhinney IR. (2000a) Medical Education, Research, and Scientific Thinking in the 21st Century (Part One of Three). *Education for Health: Change in Learning & Practice (Taylor & Francis Ltd)* 13: 15-25.

Pauli HG, White KL and McWhinney IR. (2000b) Medical education, research, and scientific thinking in the 21st century (part three of three). *Education for Health: Change in Learning & Practice (Taylor & Francis Ltd)* 13: 173-186.

Pauli HG, White KL and McWhinney IR. (2000c) Medical education, research, and scientific thinking in the 21st century (part two of three). *Education for Health: Change in Learning & Practice (Taylor & Francis Ltd)* 13: 165-172.

Polit D. (2008) *Nursing Research: generating and assessing evidence for nursing practice,* Philadelphia, Pennsylvania: Lippincott Williams & Wilkins.

Prideaux D, Worley P and Bligh J. (2007) Symbiosis: a new model for clinical education. *The Clinical Teacher* 4: 209-212.

Ratna J and Rifkin S. (2007) Equity, Empowerment and Choice: From Theory to Practice in Public Health. *Journal of Health Psychology* 12: 517-530.

Rourke J. (2006) Social Accountability in Theory and Practice. *The Annals of Family Medicine* 4: S45-S48.

Sandhu G, Garcha I, Sleeth J, Yeates K and Walker R. (2013) AIDER: a model for social accountability in medical education and practice. *Medical Teacher* 35: e1403-e1408.

Schwandt TA. (2000) Three Epistemological Stances for Qualitative Inquiry. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research.* Second ed. Thousand Oaks, California: SAGE Publications.

Schön DA. (1987) *Educating the Reflective Practitioner,* San Francisco, California: Jossey-Bass Inc.

Scott WR. (1982) Managing professional work: three models of control for health organizations. *Health Services Research* 17: 213-240.

Seggie JL. (2010) MBChB curriculum modernisation in South Africa - growing doctors for Africa. *African Journal of Health Professions Education* 2: 8-14.

Silverman D. (2005) *Doing Qualitative Research,* London: SAGE Publishers.

Smith R. (2008) The end of disease and the beginning of health. *BMJ Group Blogs.* Available at http://blogs.bmj.com/bmj/2008/07/08/richard-smith-the-end-of-disease-and-the-beginning-of-health/. Accessed May 2014

South African Council for Higher Education. (2011) Community Engagement in South African Higher Education. *Kagisano.* Pretoria: CHE.

South African Department of Public Service and Administration. (1997) Batho Pele - 'People First' White Paper on Transforming Public Service Delivery. Pretoria: Government Printer.

Stern PN. (2007) On solid ground: essential properties for growing grounded theory. In: Bryant A and Charmaz K (eds) *The SAGE Handbook of Grounded Theory.* First ed. London, UK: SAGE Publishers.

Strasser R. (2010) Community engagement: a key to successful rural clinical education. *Rural and Remote Health* 10: 1543.

Suchman A. (2006) A new theoretical foundation for relationship-centred care: complex responsive processes of relating. *Journal of General Internal Medicine* 21: S40-44.

Taylor K. (2000) Teaching with Developmental Intention. In: Associates JMa (ed) *Transformation as Learning* 1ed. San Francisco, United States: Jossey-Bass, 151-179.

The Marmot Review. (2010) *Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post 2010*. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review. Accessed 20 November 2013

The Training for Health Equity Network. (2011) *THEnet's Social Accountability Evaluation framework Version 1*.

United Nations. (2013) *We can eradicate poverty*. Available at: http://www.un.org/millenniumgoals/. Accessed 20 November 2013

United Nations Development Programme. (2000) *Millenium Development Goals*. Available at: http://www.undp.org/content/undp/en/home/mdgoverview.html. Accessed 31 July 2012

United Nations Development Programme. (2013) Reflections on Scocial Accounatbility: Catalyzing democratic governance to accelerate progress towards the Millennium Development Goals. New York: United Nations.

University of the Witwatersrand. (2003) Working Document: Core competencies - The Graduate Entry Medical Programme at Wits. Johannesburg: University of the Witwatersrand.

Vandermoortele J. (2008) Making sense of the MDGs. *Development* 51: 220-227.

Walker M, McLean M, Dison A and Peppin-Vaughn R. (2009) South African universities and human development: Towards a theorisation and operationalisation of prfoessional capabilities for poverty reduction. *International Journal of Educational Development* 29: 565-572.

Williams B and Hummelbrunner R. (2011) *Systems Concepts in Action A Practitioner's Toolkit,* Stanford, California: Stanford University Press.

Woollard B and Boelen C. (2012) Seeking impact of medical schools on health: meeting the challenges of social accountability. *Medical Education* 46: 21-27.

Woollard RF. (2006) Caring for a common future: medical schools' social accountability. *Medical Education* 40: 301-313.

World Bank. (2003) World Development Report 2004: Making services work for poor people. Washington DC: The International Bank for Reconstruction and Development/The World Bank.

World Health Organization. (1978) *Alma Ata Declaration*. Available at: http://www.who.int/publications/almaata_declaration_en.pdf. Accessed 30 October 2013

World Health Organization. (1986) *The Ottawa Charter for Health Promotion*. Available at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html. Accessed 30 October 2013

World Health Organization (2007). *Everybody's Business. Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: World Health Organization.

World Health Organization (2013). *Transforming and scaling up health prfoessionals' education and training: World Health Organization guidelines 2013*. Geneva: World Health Organization.

Worley P and Murray R. (2011) Social accountability in medical education – An Australian rural and remote perspective. *Medical Teacher* 33: 654-658.

Worley P, Prideaux D, Strasser R, Magarey A and March R. (2006) Empirical evidence for symbiotic medical education: a comparative analysis of community and tertiary-based programmes. *Medical Education* 40: 109-116.

Young JQ, van Merrienboer J, Durning S and ten Cate O. (2014) Cognitive Load Theory: Implications for medical education: AMEE Guide No. 86. *Medical Teacher* 36: 371-384.

Zwi AB, Zwarenstein M, Tollman SM and Sanders D. (1994) The introverted medical school - time to rethink medical education. *South African Medical Journal* 84: 424-426.

Annexure A Human Research Ethics Committee Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Dr LP Green-Thompson

CLEARANCE CERTIFICATE	**M120965**
PROJECT	The Nature of Social Accountability in South African Medical Practice and Education: A Qualitative Reflection (revised title)
INVESTIGATORS	Dr LP Green-Thompson.
DEPARTMENT	Centre for Health Science Education
DATE CONSIDERED	28/09/2012
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 26/02/2013 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Prof P McInerney

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

Annexure B: Graduate Studies Committee Approval

Faculty of Health Sciences
Private Bag 3 Wits, 2050
Fax:
Tel: 027117172040

Reference: Ms Mpumi Mnqapu
E-mail: mpumi.mnqapu@wits.ac.za

04 June 2013
Person No: 8214410
TAA

Dr LP Green-Thompson
P O Box 88590
Newclare
Johannesburg
2112
South Africa

Dear Dr Green-Thompson

Doctor of Philosophy: Change of title of research

I am pleased to inform you that the following change in the title of your Thesis for the degree of **Doctor of Philosophy** has been approved:

From:	**Social accountability in South Africa: A qualitative reflection on the nature of the socially accountable medical professional's practice**
To:	**The nature of social accountability in South African Medical practice and education: A qualitative reflection**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Annexure C: Questions which guided participant interactions

Community focus groups:

- Tell me about your experiences of and with doctors
- What do you expect as a member of the community of your doctors
- What, if anything, do you know about the social accountability of doctors
- Do you think that doctors should be accountable to communities? If so, how do you think this should happen?
- What do you think are the major health issues in your community?
- Do you think the doctors need to get involved in issues in the community?

Student focus groups:

- What do you understand by social accountability in medical practice?
- Have you seen elements of this included in your studies over the years?
- How has this affected your views of your own future practice?

Partners in-depth interviews:

- What does the social accountability of medical practitioners mean to you?
- Tell me about the elements of this social accountability which have been part of the principles of your teaching over the years in the curriculum.
- What should the university do about developing socially accountable doctors in the curriculum?
- How can social accountability be developed and evaluated in undergraduate medical students?
- Do you think that you are socially accountable? What makes you socially accountable?
- Do you think that professional autonomy is a barrier or a support for social accountability?

Annexure D: Information sheet: Community

INFORMATION SHEET: Communities

Study title: The nature of social accountability in South African medical practice and education – a qualitative reflection

Good afternoon…….

My name is Lionel Green-Thompson. I am a doctor with a special interest in teaching medical students to become good doctors. I am doing a study on what you think makes a good doctor. I am doing this study as part of the requirements for my PhD. I will be interviewing several groups of people including students and other doctors as well as yourselves.

I invite you to participate in this research with me as we discuss what you think of doctors in general. Your part in the research would be to take in a group discussion which will last about an hour and a half to two hours (1 ½ to 2 hours).

I do not expect any risks to arise from your participation. By taking part in the discussion you will contribute ideas to improve the teaching of doctors both in South Africa and other countries.

Your participation in this study is completely voluntary. If at any time you wish to withdraw from the study even after your interview has been completed, you may do so. There will be no costs to you for this.

While every effort will be made to keep the proceedings of the group discussion confidential, I am not be able to guarantee that the other participants in the group will not speak about it elsewhere.

The discussion will be tape recorded. After this, the recording will be transcribed by me or an assistant. The tape recordings will be destroyed after six years. Confidentiality will be ensured. No identifying data will be linked to you.

For any information, please contact me: **Lionel Green-Thompson**
0824150437
Lionel.green-thompson@wits.ac.za

This study has been approved by the Wits Human Research Ethics Committee. If you wish to comment on your participation with regards to your rights please feel free to contact:

Ms Anisa Keshav
011 717 1234
Anisa.keshav@wits.ac.za

Prof P Cleaton-Jones
011 717 2301
peter.cleaton-jones@wits.ac.za

Thank you for considering my invitation to participate in the research study.

Annexure E: Information sheet: Students

INFORMATION SHEET: Students

Study title: The nature of social accountability in South African medical practice and education – a qualitative reflection

Good Afternoon Final year student

My name is Lionel Green-Thompson. I am an anaesthesiologist who is interested in the education of health professionals.

I am currently registered as a PhD student. The focus of my study is what makes a good doctor or what some may call a socially accountable doctor. In order to answer my research question, I will be conducting a series of interviews with the various stakeholders in the medical curriculum.

I invite you to participate in this research through participation in a focus group interview with other students from your year of study. The discussion will last about an hour and a half to two hours (1 ½ to 2 hours). It will be conducted by arrangement with you. I do not anticipate any risks arising from your participation, but it will contribute to how we develop the education of doctors nationally and internationally.

Your participation is completely voluntary. If at any time you wish to withdraw from the study even after your interview has been completed, you may do this. There will be no consequence of this. Our conversation will be recorded and this will be transcribed by me or an assistant. The recordings will be destroyed after a period of six years. While every effort will be made to keep the proceedings of the group discussion confidential, I am not be able to guarantee that the other participants in the group will not speak about it elsewhere.

Confidentiality will be ensured. No identifiable data will be linked to you in any way. I will be the only one able to link a transcript of your interview with your name and details.

For any information, please contact me: **Lionel Green-Thompson 0824150437**
Lionel.green-thompson@wits.ac.za

This study has been approved by the Wits Human Research Ethics Committee. If you wish to comment on your participation with regards to your rights please feel free to contact:

:	**Ms Anisa Keshav**	**Prof P Cleaton-Jones**
	011 717 1234	**011 717 2301**
	Anisa.keshav@wits.ac.za	**peter.cleaton-jones@wits.ac.za**

Thank you for considering my invitation to participate in the research study.

Annexure F: Information Sheet Partners

INFORMATION SHEET: Partners

Study title: The nature of social accountability in South African medical practice and education – a qualitative reflection

Goodday Partner in the training of medical doctors

My name is Lionel Green-Thompson. I am a doctor with a special interest in teaching medical students to become good doctors. I am doing a study on what you think makes a good doctor. I am doing this study as part of the requirements for my PhD. I will be interviewing several groups of people including students and other doctors as well as yourselves.

I invite you to participate in this research with me as we explore what this means for the education of doctors. You will be part of a group of educators or service providers who partner in educating doctors. Your part in the research would be to participate in an interview which will last about an hour and a half to two hours (1 ½ to 2 hours). It will be conducted by arrangement with you.

I do not expect any risks to arise from your participation. By taking part in the discussion you will contribute ideas to improve the teaching of doctors both in South Africa and other countries.

Your participation in this study is completely voluntary. If at any time you wish to withdraw from the study even after your interview has been completed, you may do so. There will be no costs to you for this. The discussion will be tape recorded. After this, the recording will be transcribed by me or an assistant. The tape recordings will be destroyed after six years.

Complete confidentiality will be guaranteed. Any identifying information will be kept separate and no identifiable data will be linked to your participation.

For any information, please contact me:

Lionel Green-Thompson
0824150437
Lionel.green-thompson@wits.ac.za

This study has been approved by the Wits Human Research Ethics Committee. If you wish to comment on your participation with regards to your rights please feel free to contact:

Ms Anisa Keshav
011 717 1234
Anisa.keshav@wits.ac.za

Prof P Cleaton-Jones
011 717 2301
peter.cleaton-jones@wits.ac.za

Thank you for considering my invitation to participate in the research study.

Consent form to participate in focus group discussion or interview for the study:

The nature of socially accountable medical education and practice – a qualitative reflection

I, hereby, confirm that I have read the participant information sheet for this study and I fully understand the nature of the research. I understand that I may at any stage withdraw from the interview or discussion without penalty or loss of benefits of any kind.

I have had sufficient time and opportunity to reflect on these documents and to ask questions. Of my own free will I agree to participate in the interviews for this study.

Participant's name:

_____PRINTED

Participant's signature:

_____

Date: _____

Witness Name

(printed)_____signature:_____

Annexure G: Consent Form 2

Consent form to participate in focus group discussion or interview for the study:

The nature of socially accountability in South African medical education and practice

I, hereby, confirm that I have read the participant information sheet for this study and I fully understand the nature of the research. I understand that I may at any stage withdraw from the interview or discussion without penalty or loss of benefits of any kind.

I also understand why it is necessary for the interview/discussion to be recorded and then transcribed; in that way the information that I shall give will be accurately reflected when it is analysed and reported. I also understand that if this is a focus group discussion, confidentiality cannot be ensured by the researcher.

I understand that the tapes on which the interview will be recorded will not identify me in any way (other than by my voice); that they will be transcribed by the researcher or his assistant; that they will remain in his possession securely kept until the study is complete. At this stage they will be destroyed. I understand that I may request to be present when these objects concerning me are destroyed. I understand that I may at any point withdraw my consent for the recording of an interview with me to continue and that I may then request the tape to be handed to me for destruction – all this without penalty or loss of benefits of any kind.

The researcher may take photographs of the group. I understand that these photographs may be used in reports prepared about this research study.

I have had sufficient time and opportunity to reflect on these documents and to ask questions. Of my own free will I declare that the interview as described above may be recorded.

Participant's name: _____PRINTED

Participant's signature: _____

Date: _____

Witness Name (printed)_____signature:_____

Annexure H: Information Sheet: National PhD seminar

Study title: The nature of social accountability in South African medical practice and education – a qualitative reflection

Dear Colleague

My name is Lionel Green-Thompson. I am an anaesthesiologist who is interested in the education of health professionals. I am currently registered as a PhD student. The focus of my study is what makes a good doctor or what some may call a socially accountable doctor. I have conducted focus groups and interviews amongst several communities, partners in the education of doctors and final year medical students.

This seminar is a final step of the research process which will examine the emergent theoretical framework for social accountability. I have invited you to participate in this research with me in order to validate the framework which I propose. Your part in the research is to participate in a seminar in which participants have been selected from a number of national medical schools. The other participants are involved in the education of medical doctors or are key individuals in the health science education environment.

The seminar is being conducted in Johannesburg and will be structured as a series of discussions about key parts of the emergent framework.

I do not anticipate any risks arising from your participation, but it will contribute to how we develop the thinking about social accountability in the education of doctors nationally and internationally.

The proceedings of the seminar will be recorded and transcribed by me or an assistant. The recordings will be destroyed after a period of six years.

Confidentiality cannot be ensured through the seminar. There may be opportunities to use your comments in presentations or publications which emerge from this conversation. I would request that you consider granting consent for this, please.

For any information, please contact me: **Lionel Green-Thompson** **0824150437**
Lionel.green-thompson@wits.ac.za

This study has been approved by the Wits Human Research Ethics Committee. If you wish to comment on your participation with regards to your rights please feel free to contact:

Ms Anisa Keshav **Prof P Cleaton-Jones**
011 717 1234 **Anisa.keshav@wits.ac.za** **011 717 2301** **peter.cleaton-jones@wits.ac.za**

Thank you for considering my invitation to participate in the research study.

Annexure I: Consent Form National PhD Seminar

National PhD Seminar – March 2014

The nature of socially accountable medical education and practice – a qualitative reflection

I, hereby, confirm that I have read the participant information sheet for this study and I fully understand the nature of the research. I understand that I may at any stage withdraw from the interview or discussion without penalty or loss of benefits of any kind. I have had sufficient time and opportunity to reflect on these documents and to ask questions. Of my own free will I agree to participate in the national seminar to review a framework emerging from the study data.

I hereby give consent for the recording and transcription of the discussions held during the seminar.

Participant's name: _____PRINTED

Participant's signature: _____

Date: _____

Witness Name (printed)_____signature:_____

I hereby give consent to be quoted by name in any materials which may emerge from the discussions held at the seminar in publications or presentations.

Participant's name: _____PRINTED

Participant's signature: _____

Date: _____

Witness Name (printed)_____signature:_____

Annexure J: Reflection document for National PhD Seminar: Exemplar

The nature of socially accountable South African medical education and practice – a qualitative reflection

National PhD Seminar to evaluate emergent theory: Unifying Theoretical Framework

Does this theory fit the context of social accountability emerging from the categories identified?	
Initial thoughts	Post discussion thoughts
Is the theory relevant and important?	
Initial thoughts	Post discussion thoughts
How flexible is this theory? How accessible is it?	
Initial thoughts	Post discussion thoughts
Does this theory work in your context of health sciences education? How general is this theory?	
Initial thoughts	Post discussion thoughts
General comments	

Annexure K: Results of National PhD Seminar

Description of panelist	Does this theory fit	Is the theory relevant and important	How flexible and accessible	Does it work in you context? Is it general?	General comments
Nurse. Clinical skills unit manager	more or less, resembles CanMeds	Yes, just consider how do-able some of the objectives are e.g. What is accountable role modelling`	tertiary/private sector might have challenges to roll out some of the aspects		
Educator	Don't like the daisy. 1. Losing one petal will have no consequence? Is this intentional? 2. does not reflect the complexity of connections. Guess trying to say whole is more than the sum of the parts. (By the way also don't like the HPCSA/CanMeds daisy for the same reasons)	see the "rose" in the diagram (if you want to stay with flowers). 1 Some issues underlie - patient centred care approach as basic 2. also allows for some overlap between elements/petals		Should the institution measure itself against this model? It makes more sense than an individual department, or individual role modelling consultant or an individual graduate? What is its intended use? I take the point of multiple starting points of (other participant).	"Ten points" should it start with verbs? Is it then true that engaged communities will automatically empower?
Physician educator	Mostly fits but I struggled to identify the following elements from the preceding models: build progressive engaged student community, reconstruct professionalism. I would describe this work as a series of models rather than theories. You have built a model rather than propose a theory.	The unifying model captures the key elements. Definitely relevant and important. The model provides clear guidance about a way forward. See graphic of flower in garden from document.	This model is easy to understand but I would make a closer link to the first three models by using the same text used in the original models. So that moving between the models will be easier for the novice.	Model works in my environment (good potential) The concepts are certainly generalisable. The model allows for entry into the process @ points of greatest interest/ expertise/commitment	
Physician educator	Key themes left out: Centrality of the dr-patient relationship - the consultation as core. Reflection is a major issue/ method for addressing some of these elements seems to be missing - perhaps it is embedded. While there might be sequencing/hierarchy, I like the diagram and the possibility of champions choosing particular areas to focus on.	All the elements described are relevant - how easy they are to implement practically is another question. But if faculty can grapple with these, it will be a hugely important step forward.	very flexible - petals can be added or taken off the flower! Easy to understand (mostly). But I think that there are hierarchies that are not shown in the diagram	Very generalisable - and that is the challenge. It is quite theoretical and thus challenging to convert into pedagogy	This seems to move back from the individual/student/graduate level to institutional/faculty level. The link of social accountability to the individual patient was a light bulb moment for me.
Educator	yes, there appears continuity in the thought	yes, it is creating a broad multidimensional understanding which has practical utility	it should be flexible given the changes in the inputs y=to things like health priorities. The concepts are open and understandable > accessible	very much so, it is transformative and generalisable to my context	This pulls together the other 3 models very well. Like the concept of reconstructing professionalism

Allied professional	yes it does. It is aligned with community determined health priorities, speaks to the educator attributes and brings in the centrality of patients and the community as well as the importance of cultivating relationships in a number of ways	very relevant and very important	It requires commitment, collaboration and shared vision of several stakeholders to ensure its success	yes as above	
Educator	Theory fits the context of SA - summarise the three presented models/ categories. Needs to be explained though with text. Miss graduate attributes	Very important. Definitely relevant.	flexible and accessible can fit into my context	yes, similar issues in my context	
Description of panelist	**Does this theory fit**	**Is the theory relevant and important**	**How flexible and accessible**	**Does it work in you context? Is it general?**	**General comments**
Physician educator	yes	yes	accessible	Yes. Generalisable, though in Dept of Fam Med we already practice these concepts to some extent COPC, LCAS, WBOT	Obsession with individualism? Patient voice. Revisit HPCSA code of conduct for doctors
Educator	yes, it does generally reflect the themes that emerged and converged in the three previous models. Relies on a concept of "engagement" which will obviously have been defined earlier? Community of practice does through very strongly for me > may arise from relabeling some of the petals. Where is the patient? Are all key elements from other models clearly visible in the petals?	definitely	very flexible and accessible - can be modified and adapted easily for different contexts	yes and can be generalised globally	Could possibly be modified to cluster more closely linked ideas - curriculum - students - communities. Are all elements at equal levels or sequenced > interdependence >contingencies >oversimplified? Relabel some petals? New petals?
PhD student: social accountability	I see clear connections between your initial models and what you've brought together in this framework. I think it would be useful to create sub themes to the framework - some of the components relate very closely to one another and you could possibly group them under certain themes e.g. educational programmes to be developed by faculty	certainly	relatively flexible and accessible	think it fits well in my context	

Physician educator	yes, it does	Yes, definitely so. But how would it apply to academic /tertiary hospitals	Flexible but not easily accessible. May not work at a hospital level. Expand it at a community based level, clinics etc >empower communities - may not work at a theory level	It should but it is too general - needs to be more detailed/ specific. Change the titles of some petals. Some of those petals may be applicable in a teaching institution but not all. Some petals may work - but will require the buy in from several levels for implementation	

Annexure L: Turn it In report

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by Lionel Green-thompson

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