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Advocating for Socially Accountable Teaching and Language Resources for Australian Medical Educators

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Abstract

Embedding social accountability in medical education has long been recognised as an important driver of systemic change within complex health systems. Recent revisions to Australia's medical education accreditation standards reflect principles of socially accountable education across multiple domains—including institutional purpose, governance, community partnerships, learning and teaching, student selection, and wellbeing—emphasising community engagement, health equity, and alignment with priority population needs. These changes present a timely and strategic opportunity to advocate for and operationalize socially accountable training. This article describes the development of an innovative, systems-level approach to support this shift. The proposed social innovation introduces a dual strategy to embed Socially Accountable Medical Education (SAME) by supporting both program leaders and educators. For leaders, tailored training will focus on engaging stakeholders across the health system to co-design programs that address priority health needs and underserved populations. Key activities include needs assessments, student selection strategies, and development of rural and remote placements aligned with community priorities. For educators, a 'train-the-trainer' model will build capacity to teach SAME principles, with a focus on cultural safety, health equity, and professional values. A key feature is the development of language training for educators to support culturally safe engagement with underserved community groups. Additional resources will support clinical placement supervisors in delivering context-specific, socially accountable learning. Together, these initiatives aim to produce a health workforce that is community-responsive, culturally safe, and equipped to reduce health inequities. Positive impacts on future patient health outcomes are more likely when leaders and educators are equipped with the training and capability to implement effective SAME teaching practices and to nurture socially accountable student champions and graduates.

Introduction

Medical education in Australia is diverse and broadly defined as "*A university; or a tertiary education institution, or another institution or organisation that provides vocational training; or a specialist medical college or other health profession college*" (AMC, 2023). In this paper, we focus on Australian medical schools and programs that lead to a qualification permitting the holder to seek general registration as a medical practitioner. This does not include specialist (postgraduate) training (Ross et al., 2021).

Across Australia, there are 23 universities offering primary medical degrees, also known as primary medical programs, with a variety of entry options including:

1. Undergraduate entry, where potential students have completed and hold a secondary school qualification,
2. Graduate entry, where potential students have completed and hold a tertiary university degree qualification, or
3. A mix of both undergraduate and graduate entry.

Over the years, universities across the globe that offer primary medical education have advocated for the development and delivery of socially accountable medical education (SAME) within their medical programs. Together with educators, communities and partners, there is an expectation that medical education, research, and service align with the health and social needs of community, including underserviced communities (Buchman et al.,2016) In 2017, the International Federation on Medical Student Association (IFMSA) published a document and set of tools for students to be able to self-evaluate their medical degree for social accountability (IFMSA, 2017). The IFMSA toolkit includes template documents for students to use after their self-evaluation, to be able to approach the leadership of their medical school for missed social accountability learnings within their degree.

Often, social accountability (Boelen et al., 1995) is misaligned with social responsibility (Dharamsi et al., 2011). To clarify the distinction, social responsibility involves educators deciding which priority health and social needs will be taught, based on the general community health needs. In contrast, social accountability goes beyond responsibility by involving the medical program in collaboration with the community and key stakeholders to adapt the learning as required, ensuring fit-for-purpose graduates for the communities they will work in. Students are also taught the social determinants of health, how to identify individual and community health needs, and how to be a future change agent for the community they will serve.

The delivery and educational outcomes of SAME aim to equip graduates with the necessary skills and capabilities to serve their communities and contribute to reducing systemic health disparities. These include students providing health education, health promotion, and disease prevention activities accessible to communities while on extended clinical community placements. At one medical school in Australia, students reported that their experience of SAME cultivated a greater commitment to their own 'socially-accountable' practice, with a significant preference to practice in non-metropolitan areas (Woolley et al., 2020).

In 2021, the Australian Medical Council (AMC), the accrediting body for medical schools, updated the *Standards for Assessment and Accreditation for Primary Medical Programs* (AMC, 2023). These updates included graduate outcome statements and their domain names to the following:

- Domain 1: Clinical Practice—the medical graduate as a practitioner
- Domain 2: Professionalism and Leadership—the medical graduate as a professional and leader

- Domain 3: Health and Society—the medical graduate as a health advocate
- Domain 4: Science and Scholarship—the medical graduate as a scientist and scholar

Within the standards, healthcare refers to the responsibility of healthcare systems and professionals to address the health needs of the population, particularly those who are vulnerable or marginalized. The introduction to these standards includes definitions of community groups that experience health inequities in Australia. These are underserved community groups who have different resources and health access, often with poorer health outcomes. These may include people:

- Who are Aboriginal and/or Torres Strait Islander
- With disabilities
- From the LGBTQIA+ community
- From low socioeconomic backgrounds
- From migrant and/or refugee backgrounds and those whose first language is not English
- In rural communities

Within the four domains of the graduate outcome statement, 13 of the 61 statements include the word 'social', and clearly identify socially responsible student requirements, but less clear are the socially accountable requirements. However, under *Section 3, Accreditation Standards for medical education providers and their programs of study,* there are very clear, socially accountable, and responsible medical education statements, including: purpose, partnerships with communities and stakeholders, governance, learning and teaching, student selection, and wellbeing. These AMC accreditation standards are required to be met for every medical school in Australia to graduate students as junior doctors. The AMC provides flexibility for each of the 23 medical degree institutions for how their medical program is developed/delivered. Additionally, it is expected that each "*medical education provider recruits and trains sufficient academic staff to deliver the medical program for the number of students and the provider's approach to learning, teaching, and assessment*" (AMC, 2023).

The imperative to embed social accountability in medical education accreditation standards has long been recognised as a critical lever for change within a complex health system (Boelen & Woollard, 2009). The changes in Australia's accreditation standards are reflective of the principles of a socially accountable approach to training the health workforce and present an opportunity to engage, mentor, and partner with other health institutions in Australia, and further develop this approach in the Australian context.

Innovative Solution

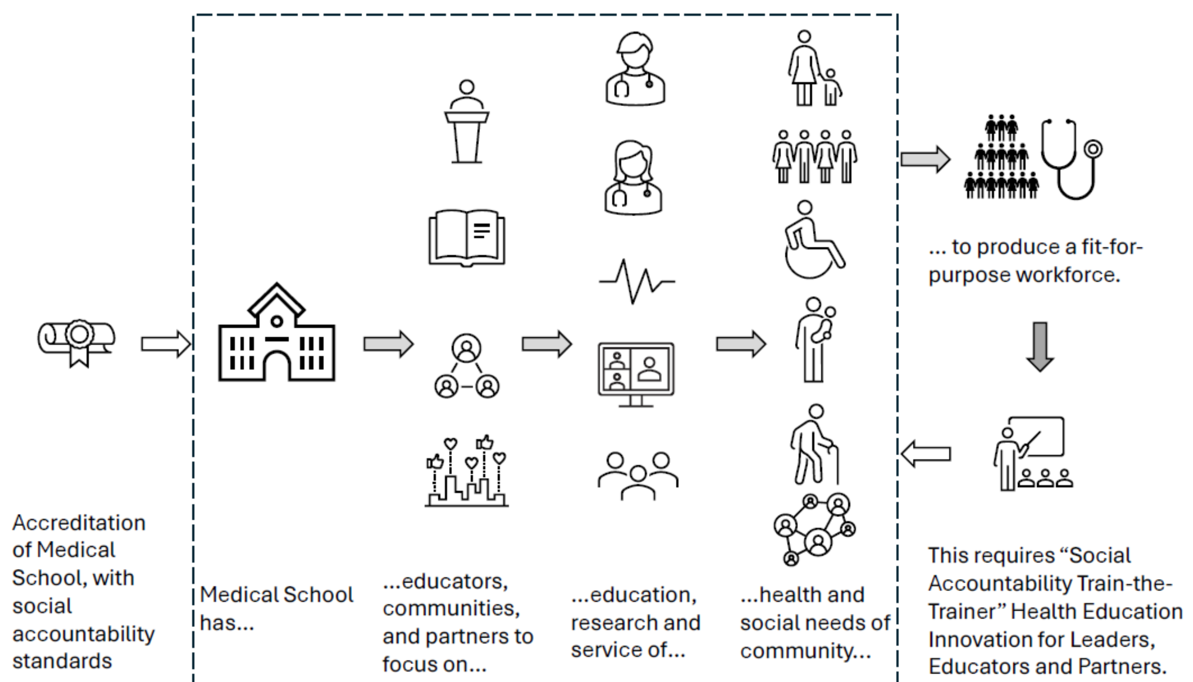
Development of a Centre of Excellence in Australia and New Zealand

With the above updated AMC accreditation standards, there are opportunities to support and provide training and resources to the leadership and academics of medical schools towards the social accountability standard requirements. The authors propose the development of a Centre of Excellence in Australia and New Zealand, partnered with Towards Unity for Health (TUFH, 2025), and other domestic healthcare training agencies.

Social Innovation – A Potential Initial Area of Focus

There is much we can do as medical educators, academics, and leaders to shape a SAME curriculum in Australian medical degrees to develop a fit-for-purpose health workforce. Due to the complexity of SAME, we propose the development of SAME training and resources for leaders and educators to deliver the socially accountable and responsible delivery and education required for students. This will help to improve patient health outcomes, increase health equity, and strengthen the health system. As seen in Figure 1, achieving this requires delivering and supporting SAME development and education collaboratively with leaders and educators, incorporating a feedback loop.

Figure 1: 'A cycle to holistically develop fit-for-purpose health professionals'



1. Program Leaders: Engagement with Partners Upstream and Downstream

This education can be delivered to leaders of primary medical programs on how to develop a SAME program with effective stakeholders and partners to engage in the development of any program reform. Training could be developed for medical program leaders in engagement with stakeholders and partners upstream and downstream to mold and develop a SAME program.

Below are some proposed program deliverables:

- A needs assessment to be completed in partnership with stakeholders > Identify and address current and emerging health priorities and underserved health and well-being priorities.

- Analyse and consider student selection strategies > Examine the extent of under-served populations represented in the student cohort. Often, student selection location (city, rural, remote) correlates with practice intention with at least one underserved group as a clinician (Larkins et al., 2015)
- Develop partnerships and placement locations for student rural training to address the mismatch between areas of greatest underserved community groups > Provide placement opportunities to encourage students (future clinicians) to work in rural or remote areas and in areas of health needs.
- Encourage and foster research activities to address health and health system change > Identify relevant national, state, or local health service systems that require strengthening and support the process as a medical leader and change agent.

2. Train-the-Trainers: Train Educators for Socially Accountable Standards

A ‘train-the-trainer’ program can be designed to equip educators with the skills to effectively teach future practitioners the recommended AMC SAME competencies. The training is to be developed for medical educators in SAME practices, with a separate section that community partners could teach for local, relevant cultural language and respectful cultural behaviours for cultural safety of underserved community groups. This is to ensure that all teachers are showcasing respectful cultural behaviours. Students can then have the opportunity to learn and practice cultural safety (Malau-Aduli et al., 2019), showcase their professional health values, and become a junior collaborative practitioner with social and community responsibilities beyond their clinical practice training. Below are some, but not all, of the key program deliverables that require further consideration in preparation for conducting this teaching program:

- Teaching, research, and service activities oriented to the priority health needs of underserved populations, and health system change
- Educator language training for each under-served community group > Encourages cultural safety of students and future patients. It can also develop educator and student empathy
- Assistance to develop partnerships and training with and for clinical placement educators > Provide student placement supervisors an understanding of the SA degree requirements, their requirements, and student requirements
- Educational resources for rural and remote placements, as the location of training makes a difference to student practice intentions > The development of key learning outcomes for rural/remote community needs

Discussion

Scaling up the proposed programs—educating leaders on SAME development and delivering train-the-trainer programs—could expand the reach and consistency of socially accountable medical education. By building capacity among leaders and educators, the approach promotes systemic change rather than isolated initiatives. This can lead to a sustainable shift in curriculum design and delivery that prioritises community health needs, equity, and responsiveness. A larger pool of trained educators ensures that future medical practitioners consistently acquire SAME competencies, fostering a workforce better prepared to address diverse community needs, particularly in underserved populations. As the programs expand,

the ripple effect can influence clinical practice, research priorities, and health service delivery. All of this requires resources, commitment across the institution, and mechanisms to ensure quality and fidelity.

Embedding SAME principles aligns with JCU CMD's strategic goals by supporting efforts to address the healthcare needs of the northern Queensland population, reduce health inequities, and enhance community partnerships in health education. By training medical leaders and educators in SAME, policies supporting rural and remote workforce development may be strengthened, as graduates are more likely to practice in non-metropolitan or underserved areas, responding to well-documented health disparities.

Conclusion

When leaders and educators lack the training and capability to implement effective SAME teaching practices and to cultivate socially accountable student champions and graduates, this can impact future health outcomes of patients.

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