Social Responsibility and Accountability
Interim Framework for UBC's Undergraduate Medical Curriculum Renewal

Background

At the completion of the first phase of UBC's MD Undergraduate Medical Curriculum Renewal process, the Dean's Task Force recommended "that a working group be struck to articulate the social responsibility and accountability framework of the MD Undergraduate Program that will lead to change in admission processes, program structures, and exit competencies."[1]

Thus, in the second phase of Curriculum Renewal, the Implementation Task Force requested that the Working Group on Social Responsibility and Accountability (SRA) renew UBC Faculty of Medicine's Social Responsibility and Accountability Framework. Once the renewed framework is approved by a wide representation of stakeholders it will be used to revise and update the Missions, Goals, and Objectives of the MD Undergraduate Program. The Social Responsibility and Accountability Framework will inform and guide other aspects of the MD Undergraduate Curriculum Renewal implementation process.

Many organizations such as professional associations, regulatory bodies, health authorities, and government recognize their obligation to address their social responsibility mandates. In the context of a faculty of medicine, a social responsibility framework guides its education, research and service endeavours.

In the course of developing this framework, the Working Group acknowledges that the framework and the medical curriculum it informs should remain extremely dynamic. Therefore, the Working Group will recommend a formal process to encourage ongoing stakeholder input ensuring that the curriculum remains current and aligned with the health care needs of communities.

More than a prescription for curriculum, the social responsibility and accountability framework provides a foundation, based on the central values of society, which will direct the implementation of curriculum renewal.

[1] UBC Faculty of Medicine. (2010). *Dean's task force on MD undergraduate curriculum renewal (pp*. 20). Vancouver, BC: Faculty of Medicine.

Social Responsibility

In medical education the terms social responsibility and social accountability are often used interchangeably. They are, however, distinct. "The concept of social responsibility suggests that faculties direct their education activities towards addressing the needs of the community, and social accountability directs that faculties should, in turn, report their efforts to address these priority health concerns to their stakeholders."[2]

As the only medical school in the province, the University of British Columbia Faculty of Medicine's primary **social responsibility** is to train competent physicians who will meet the current and future health care needs of all British Columbians, as well as those needs of national and international communities.

As conceptualized in the social accountability pentagram,[3] meeting the health care needs of the province is not UBC's sole responsibility. In fact, it requires strategic partnerships amongst policy makers, health managers, health professions, communities[4]/civil society,[5] and academic institutions.

Often it is asked whether it is the graduates or the curriculum that needs to be socially responsible. In fact, a socially responsible curriculum is needed to best develop and train socially responsible physicians.

In the training of future physicians, social responsibility has historically meant that graduates are prepared to meet the needs of society upon the conclusion of their training. The Working Group contends that, rather than waiting until they have completed their training, learners must become engaged in social responsibility initiatives throughout their undergraduate and post-graduate training program. As Canadian post-graduate program curricula are reviewed and renewed, it is expected that similar efforts to those being advanced in undergraduate reform will be necessary to enhance the social responsibility initiatives of post-graduate training. This will result in a seamless continuum of social responsibility from undergraduate education to life-long practice.

In addition to learners and the curricula, faculty members and staff of faculties of medicine are recognized as being in a unique position to address key components of social responsibility.

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[2] UBC Faculty of Medicine. (2010). *Dean's task force on MD undergraduate curriculum renewal (pp*. 16). Vancouver, BC: Faculty of Medicine.

[3] Boelen, C., Glasser, J., Gofin, J., Lippeveld, T., & Orobaton, N. (2007). Towards unity for health: The quest for evidence. *Education for Health,* 20(2).

[4] Boelen, C. (2000). *Towards unity for health: Challenges and opportunities for partnership in health development*. A Working Paper. Geneva: World Health Organization.

[5] Boelen, C., Glasser, J., Gofin, J., Lippeveld, T., & Orobaton, N. (2007). Towards unity for health: The quest for evidence. *Education for Health,* 20(2).

To embed social responsibility in the undergraduate medical curriculum, the Working Group on Social Responsibility and Accountability recommends that a specific objective be written encompassing one or more of the key elements of social responsibility for every course in the program.

Using the CanMEDS competency framework[6] in the context of undergraduate medical education, it can be concluded that graduates are only competent when they have satisfactorily met all exit competencies. The Working Group asserts that social responsibility is a key component in each of the CanMEDS roles of medical expert, professional, scholar, manager, collaborator, health advocate, and communicator. Thus, being a competent physician and meeting society's needs are neither primary nor secondary objectives; they must be pursued concurrently. A fully competent physician demonstrates social responsibility while performing each of the CanMEDS roles.

Social Accountability

Social accountability is how a faculty of medicine demonstrates that it is meeting its social responsibility mandate. Medical students, faculty members, staff, and the medical curriculum "must accept and acknowledge being held to account by society."[7] Effort must be made to regularly and systematically report on the progress being made to address the social responsibility mandate to all key stakeholders including patients, communities, government, practicing physicians, faculty, staff, and other health professionals. Therefore, it is imperative that ongoing evaluation systems are established to ensure that UBC is continuously meeting and demonstrating its social responsibility mandate.

Evaluation in this context is defined as the systematic investigation of the significance of the social responsibility framework in guiding curriculum renewal implementation. Evaluation would also measure outcomes to determine how admissions and curricular initiatives are re-aligned to meet the social responsibility mandate.

Only by the utilization of high quality evaluations can the social accountability mandate be met. That is, to demonstrate that it is achieving its social responsibility objectives, faculties of medicine must use effective evaluations guided by key standards,[8] such as utility, feasibility, and propriety defined by the Joint Committee on Standards for Educational Evaluation. These

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[6] Frank, J.R. (Ed.). (2005). The *CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care.* Ottawa: The Royal College of Physicians and Surgeons of Canada.

[7] Boelen,C. & Heck, J.E. (1995). *Defining and measuring the social accountability of medical schools (pp. 3).* Geneva: World Health Organization.

[8] Yarbrough, D. B., Shulha, L. M., Hopson, R. K., and Caruthers, F. A. (2011). *The program evaluation standards: A guide for evaluators and evaluation users* (3rd ed.). Thousand Oaks, CA: Sage

standards describe fundamental steps that should be incorporated into all evaluations. There should be authentic and continuous stakeholder engagement which includes being responsive to stakeholder feedback. It also involves the establishment of clear measurements of outcomes, and ensuring transparent and timely communication about findings, identified issues, and resolutions. It is recognized that the reporting mechanisms need to be as diverse as the stakeholders themselves. Finally, inherent in the commitment to conduct evaluations to demonstrate the extent to which the social responsibility mandate is being met, is also the commitment for ongoing improvement.

Social Responsibility Themes

The Future of Healthcare in Canada report[9] and the Stakeholder Input report,[10] both commissioned by the Dean's Task Force on MD Undergraduate Curriculum Renewal, identified key themes that were perceived to affect the context in which future physicians will practice. Some of these themes included training physicians to meet population and societal needs, identifying and addressing health disparities, diversity, chronic disease management, generalist training, enhancing physician relationships, collaborative care, sustainability, and managing certainty and uncertainty in clinical practice.

These themes and additional literature were considered by the Working Group on Social Responsibility and Accountability in developing a framework. It was decided that the following categories would best focus the renewal of the MD undergraduate medical curriculum and admissions processes: **health disparities, diversity, changing demographics, Aboriginal peoples' health, rural and remote heath care, generalist and specialist training, collaborative care, research and scholarship, health promotion and prevention and patient-centred care**.

[9] Jamieson, J. (2010). *Future of health care in Canada*. University of British Columbia.
[10] Hopkins, R., Bates, J., & Towle, A. (2010). *Stakeholder Input*. University of British Columbia.

Figure 1 Social Responsibility and Accountability Framework
Source: UBC Faculty of Medicine Working Group on Social Responsibility and Accountability

As represented in Figure 1,

- Social Responsibility is at the centre of UBC's MD Undergraduate Curriculum. It is the core value and of primary importance.
- Social Responsibility, protected by a circle around it, symbolizes the sacredness of this internal value to the medical profession.
- Spreading out, and supported by the notion of social responsibility, are ten themes that need to be the focus of the MD Undergraduate Curriculum.
- The outside circle of Social Accountability represents the interface with all external stakeholders. That is, Social Accountability is how the Faculty of Medicine displays and demonstrates that the medical curriculum is meeting its social responsibility mandate while incorporating stakeholder feedback.

Health Disparities

By promising universal access to high quality health care, Canada has been recognized as a leader in health care delivery. The unfortunate reality is that significant health care disparities exist and are becoming more pronounced in some regions both locally and globally.[11]

While addressing health disparities requires strategic partnerships, the Faculty of Medicine must tailor its curriculum to ensure that graduates are aware of and are able to manage the health care needs of all British Columbians, particularly those of vulnerable populations. This will allow them to consider the health challenges of vulnerable populations in British Columbia and around the world.

To assist in the provision of comprehensive and universal health care, the curriculum must recognize that citizens from diverse socio-economic backgrounds, cultures, religions, genders, ages, sexual orientations, and abilities reside in urban, rural, and remote areas of the province.

In order to meet the challenge of addressing health disparities, it is critical that the curriculum educate medical students about various vulnerable populations. The curriculum must also explore the social determinants that produce disparities and empower medical students on how they can best intervene.

Within the literature, the definition of disparity varies depending on the source. Social Determinants of Health: The Canadian Facts[12] considers 14 social determinants of health:

1. Income and Income Distribution
2. Education
3. Unemployment and Job Security
4. Employment and Working Conditions
5. Early Childhood Development
6. Food Insecurity
7. Housing
8. Social Exclusion
9. Social Safety Network
10. Health Services
11. Aboriginal Status
12. Gender
13. Race
14. Disability

[11] Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. (2004). Reducing Health Disparities –Roles of the Health Sector: Discussion Paper.

[12] Mikkonen, J. & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management.

The Working Group on Social Accountability and Responsibility identified the following as vulnerable populations[13] locally and globally:

- Aboriginal communities
- The socio-economically disadvantaged
- Refugees and immigrants
- Northern, rural, and remote communities
- Language minorities
- Sexual orientation (gay, lesbian, bisexual, and transgendered individuals)
- Mental health patients
- Palliative care patients
- Elderly population
- People with visible and invisible disabilities

There are several cautions which need to be explicitly noted when identifying populations as "vulnerable." The first concern is that any such list can never be all inclusive; depending on the definition of vulnerable, additional groups can always be identified. Secondly, describing a population as being vulnerable can lead to unfair generalization and stigmatization. Thirdly, it should be noted that any particular group can be rendered vulnerable at any time; a group's vulnerability status can be both static and dynamic. Finally, there must be awareness that there are individuals within privileged segments of society who can also be disadvantaged. A well-designed curriculum will be sensitive to all of these complexities.

In training future physicians to manage health disparities, aspects of the hidden curriculum must also be addressed. The Working Group acknowledges that if medical students feel that they cannot effect change at a policy or system level, they may feel helpless, apathetic, frustrated or guilty. This could lead students to not only be disengaged, but minimally motivated to effect change. The curriculum must guide the students to be aware that while, for example, they cannot change the socio-economic status of patients, they can endeavour to better understand, empathize, and advocate for them.

Efforts should be made to design the curriculum in a creative manner that will provide opportunities for medical students to be immersed in the issues of importance to vulnerable communities. For instance, students could be provided strategies to learn about health disparities, and identify problems and solutions. Inspirational stories of advocacy, particularly

[13] Vulnerable groups or populations are those individuals, at a particular point in time, who cannot protect their own needs and interests because of a combination of social, economic, political, environmental or biological influences.

of good faculty role models, can be used as they can be much more effective than a lecture or an assigned reading. The undergraduate medical curriculum should nurture the creation and development of physicians as health advocates.

Diversity

To meet the health care needs of a diverse population, it is important to have a physician population that is equally diverse. This needs to be a diversity not only of the student body, but also of faculty and staff.

i. Admissions

> In order to achieve the desired diversity in the physician workforce, Faculties of Medicine must recruit, select, and support a representative mix of medical students. In order to meaningfully serve the complex and diverse health care needs of Canadians and meet social accountability objectives, the physician must become demographically more diverse. The diversity needed in Faculties of Medicine includes dimensions such as ethnicity, religion, gender, sexual orientation, geographic origin, socioeconomic status, and a balance between those who desire to practice in generalist disciplines and other specialities.[14]

With respect to the student body, there has been a significant increase in the number of women accepted into faculties of medicine across Canada. In fact, most schools have more female than male medical students in each incoming class. Similarly, with a few exceptions, there has been an increase in diversity of students from different ethnic backgrounds.

Academic diversity – students from non-traditional science pre-medical studies – continues to enrich faculties of medicine by bringing a fresh and alternative perspective to each medical class cohort. Such diversity in the student body is valuable and should continue to be promoted and supported.

There remains, however, an underrepresentation of students from Aboriginal communities and students from lower income families in medical school.

UBC has developed a specific Aboriginal admissions program in which potential Aboriginal applicants are offered support and are given the option to pursue a unique Aboriginal

[14] Associations of Faculties of Medicine. (2010). *The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education.* Ottawa: Ontario.

admissions process. This initiative should continue and possibilities for further enhancement should be explored.

Literature indicates that in Canada, medical students increasingly come from high income-earning families.[15] While it is difficult to correct for socioeconomic disparities amongst medical school applicants during the admission selection process, there must still be proactive measures taken to ensure that a career in medicine is available to those from a variety of socioeconomic backgrounds. A multi-faceted approach by curriculum leaders and community partners to offer guidance and support to secondary school students and pre-medical students at post-secondary institutions is needed to help bridge the gap experienced by low socioeconomic status students.

Once accepted into medical school, students from diverse backgrounds should experience a curriculum and learning environment that is designed to optimize success. The learning environment should be one in which the faculty, staff and students learn, respect, encourage and welcome diversity. Curriculum should be flexible enough to allow for schedule adjustments, additional cultural/academic support, and individualized learning plans.

ii. Diversity of Faculty

While there has been an improvement in gender and ethnic diversity amongst the medical student body, this has not resulted in a more diverse composition of faculty members in academic medicine across Canada.[16]

The explanation for a lack of ethnic diversity in faculty leadership is complex and not well understood. It is recognized that this area, particularly with respect to Aboriginal faculty members, needs focused initiatives to correct.

Many factors have been associated with the underrepresentation of women in academic medicine: reproductive pressures, family responsibilities, childcare challenges, conscious and unconscious bias, workplace culture, and the development of professional identity. Addressing these barriers will lead to more female faculty members choosing academic careers, which in turn will provide positive female role models for future physicians.

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[15] Associations of Faculties of Medicine. (2010). *The Future of Medical Education in Canada (FMEC): A Collective Vision for MD Education.* Ottawa: Ontario.

[16] Lois, M.N. (2010). The 21st century faculty member in the educational process—what should be on the Horizon? *Academic Medicine*, 85(9), s45-s55.

In order to fully represent aspects of social responsibility in the curriculum, efforts should be made to enhance and further develop the contribution of a variety of clinicians and basic scientists. Strategies should be initiated to recruit and retain a cadre of excellent educators, regardless of their academic background, who bring a diverse perspective to the medical student experience.

Changing Demographics

The curriculum must prepare graduates to practice with a British Columbian population that is older and more ethnically diverse than it has been in the past.

Canada's population is ageing, and the effects of this demographic shift are evident. In British Columbia proportionally, there are more seniors (greater than 65 years), and dramatically more elderly seniors (greater than 80 years) than ever before. This has a significant impact on the health care system.

Future physicians need to be adequately trained in disease processes that affect the elderly. Similarly, new models for health care delivery need to be explored and taught as this enlarging population will need to be treated by a relatively small number of physicians.

As treatment for diseases such as ischemic heart disease, diabetes, and cancer become more advanced, patients are living with these conditions for longer periods of time. This necessitates the development of curriculum that adequately trains physicians in chronic disease management including symptom management and palliative care.

Of British Columbia's population, 27.5 % are first-generation immigrants.[17] In some parts of the province, such as Surrey where 45.8% of the population is identified to be a visible minority, immigration rates are even higher. As the number of immigrants coming to British Columbia from all over the world is increasing, it is imperative that medical students be prepared to address the needs of patients from different cultures, languages, religions, and lifestyles. Concepts such as cultural competency and cultural safety must be better developed and taught. In addition, medical students need to be aware of disease processes and medical management models that are more prevalent in other parts of the world. While becoming better positioned to treat new British Columbians, this enhanced knowledge will strengthen graduates' ability to practice medicine globally.

[17] Statistics Canada. (2008). *Canadian Demographics at a Glance*. Ottawa: Government of Canada, Minister of Industry.

Aboriginal Peoples' Health

There are extreme health disparities amongst the First Nations, Inuit, and Métis peoples, as compared to the non- Aboriginal Canadian population.[18]

In renewing a medical undergraduate curriculum, consideration needs to be given to the recommendations that were made by The Association of Faculties of Medicine of Canada (AFMC) Aboriginal Health Task Group (IPAC-AFMC) and subsequently unanimously approved by the Council of Deans in 2005. They state, that all medical schools should:

a. make a commitment to increase content of undergraduate curriculum related to Aboriginal health;
b. strive for Aboriginal health curricula that respect principles of cultural competence and particularly emphasize skill-based and attitudinal themes;
c. develop, implement and evaluate core and elective curriculum that has both discrete and integrated elements and is apparent within course and clinical teaching;
d. recognize that Aboriginal health is a specialist area and requires experts such as Aboriginal faculty, local Aboriginal community members and national Aboriginal resources to develop and teach culturally appropriate Aboriginal curriculum content and context; and
e. utilize appropriate teaching methods such as experiential and interactive methods to facilitate cultural competence.[19]

In addressing the significant health disparities faced by Aboriginal peoples, attention needs to be directed to key elements of history as well as a wide variety of social determinants of health, such as, infrastructure, housing, employment, income, environment, and education.
The curriculum needs to teach future physicians that strategies for mainstream populations may be completely inappropriate and ineffective for Aboriginal peoples. To successfully intervene in the health care of Aboriginal peoples often requires a collaborative approach and a high level of cultural awareness.

Rural and Remote Heath Care

Access to optimal health care is influenced not only by social determinants of health and diversity, it is affected by geography. Many rural and remote populations of British Columbia

[18] Adelson, N. (2005). The Embodiment of Inequity**:** Health Disparities in Aboriginal Canada. *Canadian Journal of Public Health*.
[19] Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada. (2009). *First Nations, Inuit, Métis health core competencies: A curriculum framework for undergraduate medical education*. (pp. 4).

have unique health care needs that are not adequately being met. One of the challenges remains that of recruiting and retaining sufficient numbers of physicians to meet the health care needs of these communities.

> Studies indicate that the training and recruiting of physicians is taking on an 'urban centric educational paradigm'; medical schools preferentially select students and train them in an urban environment which promotes specialization and research, instilling a mindset for urban practice alone.[20]

Rather than identify rural practice and a rural lifestyle as being one with disadvantages, the medical curriculum must show that rural and remote communities in British Columbia have unique characteristics which emphasize a culture of community and an appreciation of the natural environment. Thus, medical students will understand that "rural" means much more than being "not urban."

While establishing the Northern Medical Program in Prince George, British Columbia, was meant to help address this situation, the Working Group recognizes that an ongoing multifaceted approach is necessary to meet the physician shortage in rural and remote British Columbia. It is anticipated that an admissions process that encourages and supports applicants from rural areas of the province will result in a greater number of fully trained physicians returning to their home communities. Likewise, a curriculum that exposes all students to the rewards and opportunities available in rural and remote British Columbia will promote such practices as viable career choices for future physicians. Students need to recognize the impact that health care providers, such as physicians and nurses, have on the wellness and success of communities. Finally, it is critical that medical students interact with successful physician role models who are able to lead fulfilling professional lives – clinical, educational, and research – all while residing in rural and remote communities.

Generalist and Specialist Training

To meet the health care needs of all British Columbians, there must be a full complement of both specialist and generalist physicians. It has become increasingly evident in the literature that having a family physician improves health outcomes.[21] Similarly, the role of other generalists, such as general internal medicine specialists, general pediatricians, general

[20] Herbert, R. (2007). Canada's Health Care Challenge: Recognizing and Addressing the Health Needs of Rural Canadians. *Lethbridge Undergraduate Research Journal,* 2 (1).

[21] Yves, T., Fuller-Thomson, E., Tudiver, F., Habib, Y., & McIsaac., W. (2001). Canadians without regular medical doctors: Who are they? *Canadian Family Physician,* 47, 58-64.

psychiatrists and general surgeons, are crucial in meeting the health care needs of people around the province.

It has been noted that a hidden curriculum is deterring many medical students from choosing family medicine as a career. As much of the medical students' clinical training occurs in tertiary care centres led by focused specialists, career choices are often influenced by the notion that family physicians do not "have all the answers," only specialists do. The importance and key role of generalists, such as family physicians, needs to be explicit throughout the curriculum. In particular, the four pillars of family medicine [22] need to be emphasized: the family physician is a skilled physician; the patient-physician relationship is central to the family physician's role; the family physician is a resource to a defined practice population; and family medicine is community-based.

Similarly, general internal medicine, general pediatrics, and general surgery are also disciplines to which students need increased exposure so that they may consider them as careers.

While the importance of generalists has been acknowledged, it is equally important to recognize that physicians with highly specific skills are also crucial to ensuring positive health outcomes for patients. The curriculum needs to have sufficient flexibility such that if a medical student wishes to pursue advanced experience in a narrow area, such as a subspecialty of neurosurgery or a specific focus in pathology, they must be able to do so while still meeting the requirements of the core curriculum.

The design of the undergraduate medical curriculum must ensure an adequate exposure and understanding of generalists and specialists to ensure that medical students are well positioned to make informed decisions as to their future careers. Educational experiences in environments with a variety of practice styles and opportunities for ongoing professional development would also be valuable when making career choices.

Exposure to different disciplines in medical training will also bring to light the concepts of certainty and uncertainty. That is, while patients and their families usually expect certainty, and technology can help reduce ambiguity (CT scans, tumor markers, etc.), students need to understand that a patient's care cannot be paused if the right test or diagnosis is unavailable. They need to learn and be affirmed to make best guesses, reassess a situation, and manage uncertainty. Both evidence-based decision-making and uncertainty can exist; the language in the curriculum needs to shift to account for uncertainty and intangible elements.

[22] http://fammedmcmaster.ca/undergrad/clerks/4-pillars-of-family-medicine

With the last major revision of the MD undergraduate curriculum at UBC, problem-based learning (PBL), in addition to its other benefits, was implemented as a strategy to invoke a sense of active ongoing learning by medical students. Given the dramatic advancements in medical research and the rapid evolution of standards of medical practice, it is imperative that the curriculum instill the necessity of life-long learning for future physicians.

Collaborative Care

The medical literature is overwhelmingly convincing that ideal interprofessional collaboration provides for better health outcomes.[23] Conversely, when an interprofessional health care team is dysfunctional, there may be unfortunate and negative outcomes for patients. There is an increasing understanding that health care delivery relies more heavily on health care teams of different health care practitioners.

The curriculum needs to provide learning opportunities and role models who will guide medical students to develop an understanding of how collaborative practice supports better health outcomes. Medical students need to have opportunities to work with not only colleagues in their own profession but also with colleagues from other professions to achieve the following favourable outcomes:

1. Improved understanding of collaboration
2. Enhanced mutual trust and respect
3. Improved understanding of the stages leading toward the development of collaborative relationships
4. Change in attitudes toward collaboration among health professionals
5. Increased job satisfaction among health professionals who are committed to collaboration
6. Optimal patient care
7. Increased patient functional status on discharge
8. Increased productivity, increased effectiveness of interventions
9. Working with colleagues who value, foster and are committed to collaboration
10. Enhanced professional development
11. Shared knowledge, experiences
12. Optimal support and feedback (validation, second opinion).[24]

[23] Mickan, S. (2005). Evaluating the effectiveness of health care needs. *Australian Health Review,* 29(2), 211 - 217.

[24] Makaram, S. (1995). Interprofessional cooperation. *Medical Education*, 29, 65–69.

The curriculum, and more specifically clinician role models, will need to exemplify the importance of positive attitudes towards and provide opportunities for inter- and intra-professional education and practice.

Research and Scholarship

Highlighting the significance of research, UBC Faculty of Medicine's vision statement is, "Through knowledge, creating health."[25] The curriculum needs to be designed such that medical students have an opportunity to be involved in scholarly activity in any research field that advances health.

The development of new diagnostic tools and treatments is instrumental in improving the health of individuals and entire communities. Focus on evidenced based care has meant that ongoing research is necessary to achieve better health outcomes.

While research in the context of social responsibility often refers to ethical conduct when engaged in research, such as maintaining patient confidentiality, not harming study subjects, and reporting results in an honest and objective manner, it is actually much more.

Social responsibility in research is about finding creative solutions and effective knowledge translation to address society's most complex health concerns. An essential aspect of social responsibility is to make these innovations universally available.

Health Promotion and Disease Prevention

The Association of American Medical Colleges (AAMC) through its Institute for Improving Medical Education, identified areas of population health that medical students need to study so they better understand population health needs.[26]

It is recognized that while focusing on the health of individuals has been the priority of undergraduate medical education, the importance of disease prevention and health promotion of whole populations is not only cost effective but is crucial to contain the burden of disease on health care systems.

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[25] http://www.med.ubc.ca/about_us/strategic_plan.htm

[26] Ad Hoc Committee of Deans. (2004). *Educating doctors to provide high quality medical care: A vision for medical education in the United States*. Washington, DC: American Association of Medical Colleges.

In order to be socially responsible, physicians need to be competent in methods to improve the health of entire communities. To address this need courses have been developed covering epidemiology, biostatistics, causal inference, population level interventions and preventions, principles of screening, the role of physicians in routine conditions and during emergencies.[27]

The degree to which practicing physicians will need to practice population health is variable but many of the same principles that improve the health of populations can be applied to individuals such as smoking cessation, managing obesity, reducing cardiovascular disease risk factors, and improving physical fitness.

Patient-Centred Care

Defining patient-centred care is not always straightforward. From the patient's perspective, patient-centred care occurs when the physician and team are fully focused on the needs of the patient taking into account their biological, psychological, social, and spiritual needs.

The curriculum needs to emphasize the supremacy of patient care and patient well-being. This includes abiding by the professional principles of patient confidentiality, professional-personal boundaries, respect, and honesty. A patient-centred focus to the curriculum mandates that medical students will aspire to a high level of competency in communication, empathy, and cultural sensitivity.

It should be understood that patient-centred care is not about self-sacrifice on behalf of the physician. In fact, the curriculum should emphasize that maintaining a sustainable model of patient-centred care requires that the physician achieve success in work-life balance, mindful practice, and self-reflection. Creative pedagogical approaches to reflection should be explored, such as humanities, fine art, and music.

The strength of the therapeutic alliance between a patient and their physician, as well as the benefits of relationship-based care, need to be highlighted throughout the curriculum.

[27] Finkelstein, J.A., McMahon, G.T., Peters, A., Cadigan, R., Biddinger, P., Simon, S.R. (2008). Teaching Population Health as a Basic Science at Harvard Medical School. *Academic Medi*cine, 83 (4), 332-337.

Conclusion

Although the training of physicians occurs in a university environment, this education involves more than the academic community. The insight of stakeholders, to provide a better understanding of society's needs, is critical to ensure that the curriculum is meeting its social responsibility mandate.

Physicians and their health professional colleagues exert a powerful effect on the lives of individuals and communities. Acknowledging this position of privilege, physicians recognize that they also carry significant responsibilities. The manner in which these responsibilities are addressed by the Faculty of Medicine is demonstrated in its educational, research, and service endeavours.

Implementation of a renewed curriculum must maintain a focus on the social responsibility themes of **health disparities, diversity, changing demographics, Aboriginal peoples' health, rural and remote heath care, generalist and specialist training, collaborative care, research and scholarship, health promotion and prevention, and patient-centred care**. A carefully designed and implemented evaluation and reporting system will meet the curriculum's goals of being social accountable.

Social responsibility in the undergraduate medical curriculum at the University of British Columbia is about valuing patients and their communities.

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