

ORIGINAL RESEARCH

Exploring how medical graduates perceive and enact social accountability during their first five years of practice

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Abstract

Background: Social accountability (SA) is a guiding principle of many medical schools, yet little is known about how institutional aspirations for socially accountable practice are translated into the realities of early clinical practice. This study explored how graduates from a medical school with a SA mandate perceived and enacted SA during their first five years of independent practice.

Methods: We employed an explanatory sequential mixed-methods design. In the quantitative phase, a questionnaire informed by DeVellis' framework for scale development was distributed to recent medical graduates within their first five years of practice. Six semi-structured individual interviews were conducted with graduates from three training sites of a Québec medical school. Two researchers coded interview transcripts and data were analyzed thematically.

Results: Findings from the questionnaire indicated that most respondents strongly endorsed the importance of SA but reported uneven preparedness to apply it in practice. Qualitative findings were organized around five themes: 1) defining and appropriating SA through core values; (2) translating SA values into everyday practice; (3) navigating systemic and moral tensions; (4) the influence of training and role models; and (5) a broader orientation toward advocacy, prevention, and collective leadership.

Conclusions: While participants expressed strong commitments to equity and justice, they faced constraints in translating these values into practice. Findings suggest that SA is experienced less as a fixed competency than as a dynamic orientation that graduates continually negotiate within the realities of early clinical practice. These findings highlight the importance of aligning training, mentorship, and health system structures with the aspirations of socially accountable medical education.

Explorer comment les diplômés en médecine perçoivent et mettent en œuvre la responsabilité sociale au cours de leurs cinq premières années de pratique

Résumé

Contexte : La responsabilité sociale (RS) constitue un principe directeur de nombreuses facultés de médecine, mais on sait peu comment elle se traduit dans la pratique clinique en début de carrière. Cette étude explore comment les diplômés d'une faculté de médecine ayant un mandat de RS perçoivent et mettent en œuvre la RS au cours de leurs cinq premières années de pratique autonome.

Méthodes : Nous avons utilisé une approche explicative séquentielle à méthodes mixtes. Dans la phase quantitative, un questionnaire inspiré du cadre d'élaboration d'échelles de DeVellis a été administré à de récents diplômés en médecine au cours de leurs cinq premières années de pratique. Six entrevues individuelles semi-structurées ont été menées auprès de diplômés de trois sites de formation d'une faculté de médecine du Québec. Les transcriptions des entrevues ont été codées par deux chercheurs et les données ont été analysées thématiquement.

Résultats : Les résultats du questionnaire ont indiqué que la plupart des répondants reconnaissent l'importance de la RS, mais font état d'une préparation inégale à sa mise en pratique. Les résultats qualitatifs s'articulent autour de cinq thèmes : 1) définir et s'approprier la RS à travers des valeurs fondamentales; (2) actualiser la RS dans la pratique quotidienne; (3) gérer les tensions systémiques et morales; (4) l'influence de la formation et des modèles de rôle; et (5) une orientation plus large vers le plaidoyer, la prévention et le leadership collectif.

Conclusions : Bien que les participants aient exprimé un fort engagement envers l'équité et la justice sociale, ils ont été confrontés à des contraintes dans la mise en pratique de ces valeurs. Les résultats suggèrent que la RS est vécue moins comme une compétence fixe que comme une orientation dynamique que les diplômés négocient continuellement dans les réalités de la pratique clinique en début de carrière. Ces résultats soulignent l'importance d'arrimer la formation, le mentorat et les structures du système de santé aux aspirations de la formation médicale socialement responsable.

Introduction

Medical schools are increasingly called upon to embrace social accountability (SA), that is, to align their training with the health priorities of the communities they serve.^{1–5} In Canada, accreditation standards now explicitly expect faculties of medicine to prepare physicians who recognize their societal role and contribute meaningfully to health system improvement and community well-being.^{2,6–9} However, little is known about how early-career physicians negotiate the transition from an institutional mandate for social accountability during training to the realities of independent clinical practice. Addressing this gap is important because it provides insight into how educational intentions translate (or not) into practice, with implications for medical schools seeking to strengthen their SA mandate.

SA has been conceptualized in multiple ways, including as an institutional mandate guiding the mission of medical schools, a set of professional values, and a commitment to aligning education, research, and service with community needs.^{10–13} Despite this growing body of work, its operationalization in clinical practice remains inconsistently defined and variably enacted. Much of the existing literature has focused on curricular approaches, institutional strategies, and indicators of accountability, with comparatively limited attention to how these orientations are interpreted and enacted by physicians in real-world clinical settings.^{14–16}

Yet, even as interest in SA has expanded within medical education, relatively little is known about how medical graduates translate these principles into practice once they leave medical training. This knowledge gap is particularly important during the early years of independent practice, a period characterized by ongoing professional identity formation and increasing exposure to the structural and organizational realities of healthcare systems. Although existing studies on early-career physicians have largely examined specialty choice, practice models, and career trajectories,^{17–21} fewer studies have explored how the values fostered during training are interpreted, negotiated, and enacted within everyday clinical practice.²² Understanding how medical graduates make sense of and enact SA during this transition offers an important opportunity to examine how institutional aspirations are

translated into clinical practice and to identify where educational preparation and workplace realities converge (or diverge).^{7,23–27}

This study therefore explores how recent medical graduates perceive and enact SA during their first five years of practice. By examining how graduates translate an institutional commitment to SA into diverse early-career practice settings, this study provides insights that may help medical schools better align educational approaches with the realities of contemporary practice.

Methods

Study context

The Faculty of Medicine and Health Sciences at the Université de Sherbrooke (UdeS) has adopted SA as a guiding institutional mandate.^{10,28,29} Undergraduate medical education incorporates service learning, distributed medical education, longitudinal exposure to underserved communities, and population health perspectives. In contrast, postgraduate training pathways are more variable, reflecting differences across specialties, training environments, and clinical contexts. Exploring graduates' perspectives provides an opportunity to better understand how SA is interpreted, adapted, and enacted in diverse early practice settings, and to identify areas where training and institutional supports may better prepare physicians to respond to community needs.^{7,10,27,30}

Study design

We employed an explanatory sequential mixed-methods design,³¹ beginning with a questionnaire followed by semi-structured individual interviews. The qualitative phase served to deepen and contextualize the quantitative findings, with integration achieved through the interpretation of complementary results from both phases. A patient-partner (PS) was actively involved throughout the study through a co-construction approach,^{32,33} contributing to decisions related to study design, data interpretation, and dissemination. Ethics approval was obtained from the university's education research ethics board (#2023-4136).

Participants

Eligible participants ($n = 442$) were physicians who had completed both undergraduate and postgraduate training in medicine at the UdeS and were within their first five years of independent practice. Invitations were distributed by email through the postgraduate medical education office. Key stakeholders at each training site supported recruitment by sharing the invitation via professional networks and email. For the qualitative phase, participants who consented to follow-up were invited to participate in a semi-structured interview. Up to four reminders were sent during each phase.

Data collection and analysis

Questionnaire. We developed questionnaire items using principles from DeVellis' framework for scale development.³⁴ Item generation drew on key conceptual papers, institutional frameworks, and empirical studies describing SA within medical education. Multiple rounds of discussion among the research team were undertaken to ensure that the questionnaire reflected the study objectives and represented key aspects of SA identified in the literature. Since the questionnaire was designed to describe graduates' perceptions rather than establish a psychometrically validated measurement scale, pilot testing focused on recent graduates representative of the intended study population. Pilot testing assessed clarity, interpretability, and response processes, allowing participants to identify ambiguous wording or difficulties interpreting questionnaire items. Minor revisions were made until no further substantive changes were identified. The final instrument included 15 items across seven sections: defining SA, integration during training, key elements of SA practice, actions undertaken, facilitators and barriers, perceived self-efficacy, and socio-demographic characteristics. The questionnaire was administered in French via REDCap.³⁵ Responses were anonymous. Descriptive analyses, including frequency distributions, were conducted for items measured using a five-point Likert scale ranging from strongly disagree to strongly agree.^{36,37} Throughout questionnaire development, attention was paid to content relevance, clarity, and alignment with existing conceptualizations of SA.

Semi-structured interviews. Building on the questionnaire findings and consistent with the explanatory sequential mixed-methods design, we developed a semi-structured interview guide to explain and elaborate the quantitative results by exploring how graduates interpreted and enacted SA in practice. Participants were invited to discuss their understanding of SA, examples of its enactment, strategies used to prioritize the needs of specific populations, perceived facilitators and barriers, and suggestions for strengthening educational approaches. One-hour interviews were conducted in French, audio-recorded, and transcribed verbatim. Data were analyzed using an inductive thematic analysis following Braun and Clarke.^{38,39} This involved familiarization with the data, initial coding, iterative development of themes, and refinement through team discussion. Two researchers (AC, MF) independently coded the transcripts, and a third (TD) reviewed and compared coding to enhance analytic consistency. Themes were developed collaboratively and refined until consensus was reached. Given the focused research question and explanatory purpose of the qualitative phase, the interviews provided sufficient information power to support the development and interpretation of the themes.⁴⁰ The full research team contributed to the interpretation of findings.

Results

Results are presented in two complementary phases reflecting the explanatory sequential mixed-methods design. Questionnaire findings provide a descriptive overview of graduates' perceptions of SA in early practice. These findings are then further explored through qualitative interviews, which help explain how participants interpreted and enacted these perceptions within their clinical contexts.

Questionnaire. Invitations ($n = 442$) were sent to 246 family medicine and 196 other specialty graduates, including study objectives and eligibility criteria. Seventy-three questionnaires were opened, and 35 (7.9% response rate) were fully completed (25 women, 10 men). Thirteen were partially completed, and 25 were excluded for not meeting inclusion criteria. Respondents represented 11 of Québec's 18 administrative health regions⁴¹ and one from New Brunswick. Among respondents, 20 were in family medicine and 15 in other specialties (See Table 1).

Table 1. Sociodemographic data of respondents (n = 35)

Practice region	Eastern Townships (e.g., Sherbrooke), n = 15
	Saguenay-Lac-Saint-Jean, n = 3
	Central Québec, n = 2
	Mauricie, n = 1
	Montréal, n = 5
	Montréal, n = 1
	Northern Québec, n = 1
	New Brunswick, n = 3
	Outaouais, n = 1
	Lanaudière, n = 1
	Other, n = 2
Undergraduate training	Sherbrooke, n = 27
	Saguenay, n = 5
	Moncton, n = 3
Postgraduate training	Sherbrooke, n = 25
	Saguenay-Lac-Saint-Jean, n = 4
	Moncton, n = 3
	Montréal, n = 3
Gender	Female, n = 25
	Male, n = 10
Discipline	Family medicine, n = 20
	Internal medicine, n = 4
	Other, n = 5
	No response provided, n = 6
Acceptance to invitation for follow up interview	Yes, n = 10
	No, n = 25

Respondents' top-ranked definition of SA (Table 2) emphasized attention to equity and population needs, rather than positioning physicians as change agents.

Respondents viewed both undergraduate and postgraduate training positively overall. Nearly all agreed that their training prepared them to tailor care to individual patient needs (91% undergraduate; 94% postgraduate) and assess social determinants of health (89% and 83%, respectively). In contrast, preparation related to community resources received the lowest level of endorsement (38% undergraduate; 71% postgraduate), suggesting this remained an area in which graduates felt less prepared (Supplementary Material A).

Respondents strongly endorsed all proposed dimensions of socially accountable practice, although the level of endorsement varied across activities. Support was highest for prioritizing population health needs (100%), practising according to socially accountable principles (94%), and contributing to sustainable health service development (91%). Participation in community organizations (71%), adminis-

trative activities (69-74%), and advocacy outside clinical practice (65%) received comparatively less endorsement, suggesting greater emphasis on direct patient care than on broader systems-level engagement (Table 3).

Table 2. Ranking of the three proposed definitions of SA

Definitions	First choice	Second choice	Third choice
The obligation of medical schools to direct their education, research, and service activities towards addressing the priority health concerns of the communities they serve. This involves a collaborative process where various stakeholders (governments, healthcare providers, the public, etc.) work together to determine the most pressing health needs of the community. ⁴	10	7	18
A socially accountable physician is aware of the disparities in equitable access to healthcare, their obligations towards improving society and will prioritize society's healthcare needs. ^{42,43}	19	11	5
A socially accountable physician is convinced and willing to act as an agent of change, taking action to meet society's healthcare needs. ⁴⁴	6	17	12

A variety of priority health needs were identified by respondents reflecting the variety of clinical practice and location (Supplementary material B). Respondents mobilised strategies to give priority to a variety of equity deserving groups (Supplementary material C). Respondents most frequently identified poverty and social inequalities (86%), disease prevention (83%), elderly health (83%), mental health (86%), and substance use (86%) as priority health needs. Indigenous health (57%) and occupational health (57%) were endorsed less frequently, reflecting variation according to practice context.

Respondents identified lack of time (94%) and performance pressures related to patient volume or productivity targets (80%) as the most prominent barriers to socially accountable practice. Limited

knowledge of available community resources (82%) and uncertainty regarding actions to address social determinants of health (63%) were also commonly reported. By comparison, negative role modelling

(37%) and lack of awareness of SA among healthcare professionals (46%) were endorsed less frequently (Table 4).

Table 3. Perceptions of key ingredients for a socially accountable practice

Question stem: Your view of what is important for socially accountable practices; I think it is important to...

Statement	Totally agree	Agree	Neutral / No opinion	Disagree	Totally disagree	Total (n =)
Act as a socially accountable physician in my practice in accordance with the definition I ranked first (see first question).	20	13	2	0	0	35
Prioritize the health needs of the populations I serve.	23	11	1	0	0	35
Advocate outside my practice to raise awareness of the issues facing underserved populations.	9	13	9	2	1	34
Participate in the administrative activities (e.g. local health and social services networks (RLS), family medicine groups (GMF), medical clinics, etc.) designed to promote access to care.	12	14	6	3	0	35
Participate in the administrative activities of health and social services establishments (e.g. hospital committees) aimed at optimizing healthcare resources.	10	14	8	3	0	35
Prioritize the health needs of the populations I serve.	17	18	0	0	0	35
Get involved in our community organizations.	7	18	7	3	0	35
Contribute to the sustainable development of health services for the local community.	18	14	2	1	0	35

Table 4. Barriers to a socially accountable practice

Question: In my current practice, the following barriers hinder socially accountable practice.

Statement	Totally agree	Agree	Neutral / No opinion	Disagree	Totally disagree	Total (n =)
Negative role modeling	4	9	8	11	3	35
Lack of knowledge of available resources	2	25	2	3	1	33
Lack of awareness of SA among healthcare professionals	3	13	11	6	2	35
Lack of time	15	18		2		35
Uncertainty about the actions to be taken to address the social determinants of health	4	18	5	6	2	35
Obligation to meet imperatives in terms of numbers of patients or interventions	11	17	4	2	1	35

Perceived self-efficacy was generally high. Almost all respondents believed that addressing priority health needs (94%) and improving access to care for underserved populations (94%) could have meaningful impact. However, only half reported being familiar with community organizations relevant to their practice (50%), reinforcing earlier findings regarding preparedness to connect patients with community resources (Supplementary material D).

Taken together, the questionnaire findings suggest that while graduates broadly endorse the principles of SA, translating those principles into everyday practice remains more complex. Consistent with the explanatory sequential mixed-methods design, the subsequent qualitative phase was undertaken to better understand how graduates interpreted these tensions and negotiated the enactment of SA within clinical contexts.

Semi-structured interviews. Of 10 graduates who consented to follow-up, six early-career physicians participated in individual interviews. We conducted semi-structured interviews with six physicians, four from family medicine, whose perspectives were analyzed across five interrelated themes: (1) defining and appropriating SA through core values; (2) translating SA values into everyday practice; (3) navigating systemic and moral tensions; (4) the influence of training and role models; and (5) a broader orientation toward advocacy, prevention, and collective leadership. See Supplementary Material E for illustrative participant quotes.

Theme 1. Defining SA through core values

Participants described SA as grounded in values of equity, justice, inclusion, and accessibility, yet inherently evolving and context specific. One participant admitted, “It’s a term that’s a bit vague [...] we have several types of responsibilities, toward patients, the discipline, colleagues” (P2). For most, SA was not a static competency but an ethical compass guiding reflection and action within complex systems. “Being socially accountable,” explained another, “means integrating values like equity and inclusivity into practice and making conscious choices about whom and how to serve” (P6). Across accounts, SA appeared as part of a broader identity-building process, a way of situating oneself as a professional within a complex moral landscape rather

than adherence to a single definition. This finding complements the questionnaire, where respondents favoured definitions emphasizing equitable care over physician advocacy or change agency.

Theme 2. Translating SA values into everyday practice

Participants enacted SA through small, context-responsive acts, prioritizing marginalized patients, adapting care to resource limits, and seeking fairness in access. One participant noted, “I try to optimize what I can offer to those who need it most, considering each patient’s reality” (P2). For many, these gestures were quiet but constant, reflecting a longitudinal commitment to complex and underserved populations. “I started taking on a lot of patients with complex problems [...] that’s how I felt I was putting social accountability into my practice” (P6). Such enactment was described as pragmatic and situated, a continuous balancing act between intention and system constraints. This emphasis on individualized and context-specific actions aligns with questionnaire findings, where direct patient care was prioritized over broader system-level engagement.

Theme 3. Navigating systemic and moral tensions

Despite their conviction, participants faced barriers such as workload, time pressure, scarce resources, and ambiguous institutional expectations. “It takes energy [...] it’s always easier to go with the flow. Energy and time are the main barriers” (P3). These strains created a sense of moral tension between professional ideals and structural realities. One participant reflected, “We end up becoming cynical [...] saying to ourselves, it’s not my little business” (P4). SA, for some, thus shifted from a motivator to a moral burden, valued in principle but difficult to sustain without organizational support.

These tensions were not experienced uniformly but reflected varying degrees of alignment between personal values and practice contexts. Consistent with the questionnaire findings, lack of time and institutional constraints were identified as key barriers to enacting SA. While grounded in participants’ efforts to enact SA, these accounts also highlight how

broader working conditions shape the possibilities and limits of such engagement.

Theme 4. The influence of training and role models

Participants consistently emphasized the formative power of education and mentorship in shaping their understanding of SA. Few recalled explicit teaching: “I don’t remember discussions or readings on social accountability [...] that would have helped us start asking these questions early” (P2). Experiential learning, rotations with vulnerable populations, reflective discussions, and contact with supervisors who are engaged in their community, was described as transformative. “I had role models who challenged me and influenced my practice through their sensitivity and desire to do better” (P6). When embodied by mentors, SA became a lived example rather than a theoretical concept, fostering continuity between training and professional identity. Conversely, when messages are ambiguous or absent, engagement remains superficial. Similarly, questionnaire findings identified community resources as an area of lower perceived preparedness, reinforcing participants’ descriptions of implicit rather than explicit instruction during training.

Theme 5. A broader orientation toward advocacy, prevention and collective leadership

Some participants extended SA beyond individual care to population-level and systemic engagement, organizing services, promoting prevention, or advocating publicly. “It’s worthwhile to teach more broadly, to increase health literacy [...] sometimes it takes broader campaigns to reach people” (P4). Others described speaking out when misinformation or inequity conflicted with professional values: “If my colleagues don’t speak out, I’ll do it, someone has to” (P3). These accounts illustrate an emerging, though fragile, social leadership; a vision of medicine as collective action toward equity and societal wellbeing. Notably, while advocacy and broader system-level engagement were less prominently endorsed in the questionnaire, these dimensions were more fully articulated in interviews, suggesting a difference between perceived priorities and enacted or aspirational practices.

Discussion

This study provides insight into how early-career physicians interpret and enact SA within their clinical practice. Across both quantitative and qualitative findings, participants expressed an endorsement of SA as a set of professional values, particularly related to equity and responsiveness to patient needs. At the same time, they reported challenges in translating these values into practice, highlighting the complexity of translating institutional aspirations into individual professional practice.

Our findings suggest that graduates reinterpret the concept of SA within the realities of their own practice environments rather than simply applying a predefined institutional conceptualization. Participants emphasized its grounding in values such as equity, inclusion, and justice, while also noting its conceptual ambiguity. These findings are consistent with prior literature describing SA as an aspirational and evolving construct that is variably interpreted in practice.^{12,15,16,28,44,45}

A central tension identified in this study lies between participants’ commitment to SA and the structural realities of clinical environments.^{46,47} As reflected in both the questionnaire and interview data, graduates appeared to negotiate, rather than simply implement, socially accountable practice as they balanced patient needs, institutional expectations, and available resources. These findings align with existing work highlighting how system-level factors shape the implementation of equity-oriented practices in clinical settings.^{47–50}

Importantly, this tension appears particularly salient in early career, a period characterized by increasing autonomy, exposure to organizational expectations, and ongoing professional identity formation.⁵¹ Participants described navigating these demands while attempting to maintain alignment with values emphasized during training. In some cases, this resulted in a sense of dissonance between ideals and practice conditions, echoing previous studies describing moral tension and early-career vulnerability to disengagement.^{45,52}

The influence of training and role models was identified as an important, though inconsistent, factor in shaping participants’ understanding of SA.⁵¹ While experiential learning and exposure to engaged clini-

cians were described as impactful, participants reported limited explicit teaching on the concept itself. This suggests that SA may be transmitted more implicitly than intentionally within training environments, potentially contributing to variability in how it is understood and enacted.⁴⁶

Notably, while advocacy, community engagement, and system-level involvement were less prominently endorsed in the questionnaire, these dimensions were more fully articulated in the qualitative interviews. This divergence suggests that such activities may be perceived as less accessible or less clearly defined in early practice, despite being recognized as part of socially accountable care.^{42,43} Together, these findings point to a form of SA that is locally enacted, pragmatically adapted, and shaped by both individual commitments and structural conditions.⁵³

Taken together, these findings highlight a broader challenge: although SA is widely promoted at the institutional level, its realization in practice remains uneven and context-dependent.^{11,44} Supporting its enactment may therefore require not only curricular attention, but also organizational conditions that enable physicians to act on these commitments in sustainable ways.^{42,47,53}

Finally, while our institution has since implemented curricular reforms in which SA is more explicitly addressed, educational approaches alone are unlikely to ensure its enactment in practice.^{12,16} Our findings therefore suggest that the challenge is not solely how medical schools teach SA, but how educational experiences, workplace environments, and health system structures collectively influence its enactment throughout early professional practice. Future research could explore how curricula, alongside these contextual factors, shape the enactment of SA in early practice.

Limitations

This study has several limitations. The sample size was modest, particularly for the qualitative component, and participants were drawn from a single institution, which may limit transferability to other contexts. Although based on six interviews, the themes reflected recurring patterns across participants and were interpreted alongside the quantitative findings within an explanatory sequential

mixed-methods design. The consistency of participants' accounts, interpreted alongside the quantitative findings, supports the credibility of the thematic interpretation while acknowledging that additional perspectives may have further enriched the analysis. Participation was voluntary and may have attracted individuals more attuned to SA, introducing potential selection bias. Data were self-reported and may reflect socially desirable responses. In addition, while all participants shared a common undergraduate training context, their postgraduate experiences varied, which may have influenced how SA was interpreted and enacted. Finally, this study focuses on early-career physicians and does not capture how engagement with SA may evolve over time.

Conclusion

Graduates from a medical school with a SA mandate describe enacting SA in nuanced, context-sensitive ways that reflect both personal commitments and structural constraints. Their engagement spans from day-to-day clinical care to, at times, broader advocacy-oriented actions, but appears shaped by the conditions of early practice. These findings suggest that, without supportive institutional and organizational structures, such efforts may remain difficult to sustain. Rather than viewing SA as a competency that is acquired during training, our findings suggest it is more appropriately understood as an evolving professional orientation that is continually negotiated within diverse practice environments. Supporting this process will require attention not only to educational experiences but also to the organizational and structural conditions that enable socially accountable practice.

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The authors have no competing interests to declare.

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