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Leadership as a catalyst for advancing social accountability in health professions education: AMEE Guide No. 187

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ABSTRACT

Social accountability (SA) has become a key principle for health professions education, urging institutions to align their actions with the health priorities of the populations they serve. Despite its importance, many schools struggle to implement SA effectively, often due to fragmented leadership development and a lack of institutional frameworks. This AMEE Guide positions leadership as a strategic, system-wide driver of social accountability. Drawing on global case studies, established leadership models, and institutional evidence, it explains how leaders can translate SA from mission statements into measurable outcomes. The Guide introduces the SA values and links them to leadership practices. It offers practical recommendations across three levels: individual competencies, institutional mechanisms, and systemic enablers. The Guide highlights leadership models and demonstrates their application through detailed examples from institutions worldwide. By integrating leadership theory with practical strategies, the Guide provides a pathway for academic leaders to embed SA into their institutions' core practices through inclusive governance, responsive curricula, community partnerships, impact-driven research, and ongoing cultural change. It equips educators, deans, faculty developers, and policymakers with the tools needed to foster leaders capable of transforming medical and health professions education into a force for equity and social good.

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Leadership; social accountability; medical/health professions education; stakeholder engagement; institutional transformation

1. Background

Social accountability refers to 'the obligation of medical schools to direct their education, research, and service activities toward addressing the priority health concerns of the community, region, and nation they have a mandate to serve'. The health priorities are to be identified jointly with partners including community members [1]. This principle highlights the necessity for medical and health education institutions to align their primary functions with the health priorities of the communities they serve and the health systems they support. Over time, social accountability has become a fundamental expectation for institutions striving to show relevance, equity, and public value. It demands schools to produce graduates who are socially accountable, undertake research that shapes policy and practice, and form active partnerships with external

stakeholders, including patients, communities, governments, and healthcare providers [2,3].

To put this vision into action, medical and health professions schools must adopt and implement four core values that form the basis of social accountability: relevance, quality, cost-effectiveness, and equity [1]. These values are crucial in guiding how institutions develop curriculum, provide teaching and learning activities, engage in research, and deliver services that effectively address community needs [4]. These four values offer a practical foundation for socially accountable education. Relevance ensures that institutional efforts address the most pressing health needs of the population, particularly among underserved groups. Quality emphasizes person-centered care that is coordinated, comprehensive, and responsive to individual and community needs. Cost-effectiveness focuses on optimizing resource use to maximize health outcomes at both

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Practice points

- **Align Academic Priorities with Community Health Priorities:** Co-create a bold and inclusive vision through broad consultation, aligning institutional priorities with clearly defined community and population health needs.
- **Establish Continuous, Inclusive Engagement Mechanisms:** Formalize and resource sustained engagement through community and intersectoral partnerships to foster trust, relevance, and co-ownership of academic initiatives.
- **Design Enabling Institutional Structures:** Develop and support inclusive governance models, strategic partnerships, and intersectoral working groups that help operationalize social accountability through system-level integration.
- **Integrate Leadership Development Across All Levels:** Invest in faculty and student leadership programs that build capacity in equity-focused, system-oriented, and community-responsive leadership aligned with social accountability.

individual and population levels. Equity promotes fair and equal access to health services for all, regardless of socioeconomic status or background. Together, these values guide medical schools in aligning their missions with societal expectations and health system goals [5].

Social Accountability of medical and health professions institutions (SA) has evolved from a conceptual aspiration to become a defining benchmark for how medical and health professions schools contribute to the public good [1]. Today, social accountability is essential for health professions institutions seeking to remain relevant, credible, and impactful. The imperative for socially accountable education has intensified amid persistent health inequities, the rising burden of chronic diseases, workforce shortages, and the failure of many health systems to ensure equitable access to care [6].

The expectations were further magnified by the COVID-19 pandemic, which exposed systemic weaknesses and reinforced the need for responsive, resilient health systems—and the educational institutions that support them [7]. Within this evolving context, leadership has emerged as a central lever for translating institutional mission into measurable social impact. Leadership shapes strategic direction, institutional culture, curriculum reform, stakeholder relationships, and research priorities. It is a key mechanism by which SA moves from rhetoric to reality [8]. Effective leadership

must be value-driven, and embedded across institutional systems, influencing not just decisions but the culture and operations of health professions schools. Yet, despite its importance, leadership development remains inconsistently addressed. Many institutions lack structured strategies to develop the leadership required for a socially accountable institution. Where leadership programs do exist, they often emphasize administrative functions or personal traits over system-level change and social responsiveness [9].

Existing leadership style such as transformational, adaptive, servant, and collaborative leadership—offer valuable frameworks, especially in health professions education [10,11]. However, these styles are underutilized or poorly integrated into institutional practice. Few are explicitly linked to the competencies and outcomes required for socially accountable medical education. As a result, leadership development remains fragmented, and the translation of theory into practice is often superficial. Furthermore, institutional structures and governance mechanisms that support leadership development and leadership skill building is often underdeveloped or altogether absent.

This disconnect between leadership theory, institutional practice, and SA outcomes highlights the need for targeted, practical guidance. Medical schools require clear strategies to identify, cultivate, and support leadership that aligns with their social mission [12]. They need evidence-informed tools to design programs, guide faculty development, and evaluate institutional progress [13]. They also need adaptable examples from real institutions that demonstrate how leadership can drive meaningful and measurable change [14].

This AMEE Guide addresses a critical need by offering a clear, action-oriented framework for how leadership can actively drive SA in medical and health professions education institutions. Drawing on global evidence, leadership styles, and real-world case studies, it provides practical, context-sensitive guidance for translating mission into action. It presents leadership as a strategic institutional function—intentional, evidence-informed, and essential for aligning health professions education with community health priorities. By embedding strategic leadership within institutional culture and structures, schools can ensure lasting transformation and relevance at the level of the individual, institution, and system.

2. Core concept: Leadership as a catalyst for social accountability

In Health Professions Education, leadership is not merely a functional role within medical education—it is a transformative force that enables individuals and institutions to fulfill their social accountability mandate [15]. In this context, leadership extends beyond administrative authority to encompass

vision-setting, culture-shaping, stakeholder engagement, and system-wide change [16] responding to health needs. Effective leadership is the catalytic mechanism that translates institutional mission into measurable social impact [17].

Growing evidence shows that when leadership is aligned with SA values - relevance, equity, quality and cost effectiveness - medical schools and other health professions institutions are more likely to engage communities meaningfully, adapt curricula to local health priorities, and design research agendas addressing pressing societal issues [18]. Leaders can influence institutional direction by building consensus around shared values, co-creating policy directions, and mobilizing internal and external resources [19]. In doing so, they create the necessary conditions for sustainable reform [20]. Sustained, inclusive engagement with communities, learners, faculty and frontline interest holders further ensures that leadership initiatives remain grounded in real-world relevance. Leadership can embed social accountability into the DNA of educational and research systems through a renewal of policies, practices, and culture. Globally, examples illustrate how leadership has functioned as a driver of transformation. In British Columbia, Canada, education leaders structured education around community-embedded learning [21], to better address rural and Indigenous health disparities [22]. Similarly, in the Philippines at the Ateneo de Zamboanga University School of Medicine (Philippines), educational leaders created a 'sandwich model' of education, alternating classroom and community immersion to ensure educational relevance [23]. Likewise, in South Africa, the Nelson R. Mandela School of Medicine leaders use leadership-driven community engagement to structure its health curriculum around the needs of underserved populations [24]. Such transformation isn't just

limited to education, community-engaged research structures can also help drive change. For example, leaders at NOSM University have launched a multidisciplinary research center dedicated to advancing social accountability through an embedded, networked approach (REF). In each case and across educational and research activities, leadership is supported by institutional structures that foster continuity, accountability, and stakeholder participation.

3. The mission of medical schools and social contract

The mission of a medical school sets the foundation for its identity, priorities, and obligations to society. In socially accountable institutions, the mission extends beyond the walls of the institution to encompass active contributions to local community health and well-being [25]. This means that education, research, and service must be a dynamic process of identifying and actively participating in interventions that address clearly defined local, national, or regional health needs. When embedded into the mission, SA becomes a guiding principle that influences everything from curriculum design to graduate outcomes [13,26]. It also becomes an important lever for contributing to system transformation; see Figure 1 Social accountability continuum. The figure illustrates the dynamic relationship between socially accountable health professional education, healthcare service delivery institutions, and equity-oriented healthcare systems. Socially accountable education produces graduates who practice in socially accountable institutions. These institutions contribute to healthcare systems that align resources, policies, and services to address the priority health needs of local populations.

Medical and health professions institutions founded with a commitment to underserved

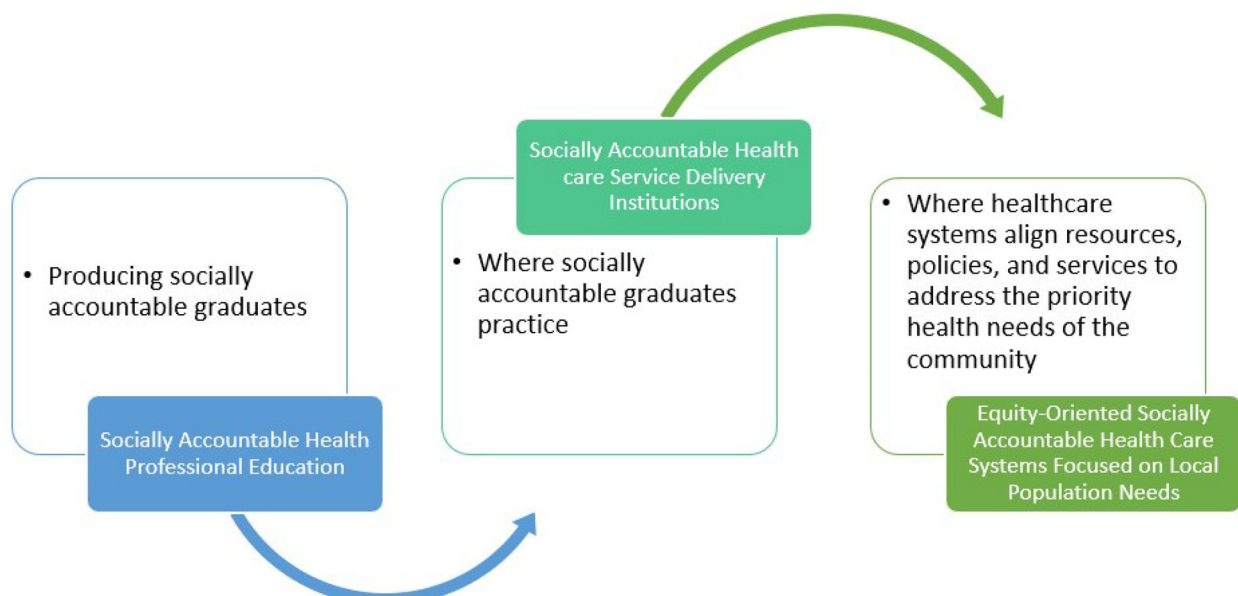


Figure 1. Social accountability dynamic.

Social Accountability: Canadian Example

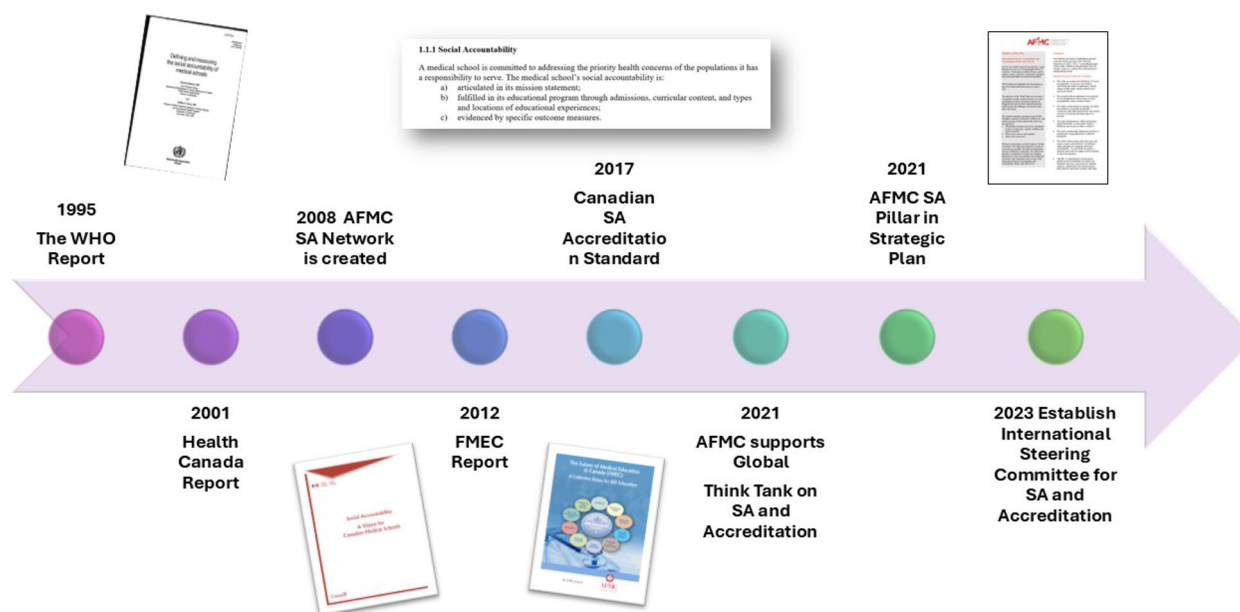


Figure 2. Evolution of social accountability in health professions education: the Canadian example.

populations often structure their educational programs around real-world health challenges [27]. These institutions emphasize community-based education, longitudinal placements, and interprofessional collaboration, thereby training graduates who are not only clinically competent but also socially responsive [2,28]. Mission-aligned schools prioritize inclusivity in admissions, recruit students with a demonstrated commitment to service, and prepare them to work in settings with limited resources [29,30].

This alignment between mission and operations enables medical schools to act as public institutions of community engaged service—not just academic centers. The mission statement becomes an actionable blueprint that directs institutional strategy toward measurable community impact [31]. Institutions that revisit and revise their missions in response to community feedback are better positioned to remain relevant and impactful in evolving health ecosystems [27,31]. However, aligning mission with outcomes requires institutional frameworks and leadership support to ensure accountability, sustainability, and responsiveness.

3.1. National and governance support: The Canadian example

The Canadian approach offers a well-documented model of how national-level vision, governance structures, and institutional alignment can operationalize SA over time. Drawing on the World Health Organization's foundational definition, Canadian

medical schools have embedded SA as a system-wide organizing principle across education, research, and service [32]. Rather than treating it as a peripheral value, they use it as a lens for institutional transformation through four key levers (see Figure 2), namely 1) government endorsement (Health Canada), 2) launch of a national SA Network (Association of Faculties of Medicine in Canada), 3) development of an accreditation standard (Social Accountability 1.1.1), and lastly 4) aligned strategic priorities at the national and medical school levels. Figure 2 illustrates a timeline highlighting key milestones in embedding social accountability (SA) into Canadian medical education. Starting with the 1995 WHO report, the process includes the creation of the AFMC SA Network in 2008, incorporation of SA in accreditation standards in 2017, integration into AFMC's strategic plan in 2021, support for global SA efforts in 2021, and the establishment of the International Steering Committee for SA and Accreditation in 2023. Reports from Health Canada (2001) and FMEC (2012) provided additional national direction.

A distinctive feature of the Canadian model is its operationalization of the 'social contract' between medical institutions and society [33]. This concept goes beyond professional ethics to demand that schools act as responsive agents of health system reform. Canadian schools identify community needs through partnerships with patients, health systems, Indigenous communities, and policy-makers, set shared priorities, and co-design responses. These collaborative mechanisms are institutionalized *via* advisory councils,

Table 1. How medical schools operationalize their core roles to advance SA (extracted from *SA a vision for Canadian medical schools*) [36].

Domain	Focus area	Institutional approach	Potential outcomes
Education	Curriculum	Integrates SA, emphasises equity, includes community-based learning.	Graduates with relevant skills to address population health needs
	Admissions	Adopts inclusive criteria to attract diverse and community-committed applicants	Increased representation and graduate deployment in underserved areas
	Learning Environment	Designs inclusive, reflective, and support-rich environments for learner development	Enhanced learner engagement, well-being, and preparedness for community service
Research	Agenda Setting	Aligns research priorities with local and national health needs	Solutions that are context-specific and socially relevant
	Conduct and Ethics	Promotes community-partnered research with strong ethical oversight	Stronger community trust and improved research impact
	Dissemination	Ensures findings are accessible, transparent, and communicated to stakeholders	Research that informs practice and policy change
Health Care Service	Clinical Training	Provides placements in diverse, often underserved, real-world clinical settings	Clinicians better equipped to serve in primary and rural care
	Institutional Outreach	Runs health outreach programs, mobile clinics, and preventive initiatives	Increased access to care and community health literacy
	Interprofessional Work	Implements collaborative, team-based training and service delivery models	Improved coordination and quality of patient care

governance roles for community members, and transparent feedback systems. Dedicated roles for social accountability, cross-functional planning committees, and integrated performance frameworks further institutionalize leadership and governance aligned with SA.

This model also reorients research from purely academic inquiry to public service. It encourages community-based, partnered and needs-based research, with an emphasis on reducing inequities and informing healthcare delivery. Simultaneously, education becomes team-based, interprofessional, and community-centered—deliberately exposing students to underserved populations and real-world complexities [34]. Admissions policies are equity-focused, and evaluation frameworks include indicators such as graduate retention in underserved regions, community health outcomes, and research relevance. Leadership plays a critical enabling role, Canadian institutions have created dedicated SA units, vice-deanships for social accountability, and cross-functional committees that integrate SA principles into strategic planning, curriculum governance, and performance measurement [9]. This systemic approach ensures that SA is not dependent on individual champions but is embedded in institutional culture and sustained through structures and policies. Importantly, public reporting and continuous evaluation drive institutional learning and refinement [35]. This commitment to accountability ensures that schools remain aligned with their social mandate, even as population needs and health systems evolve. As such, the Canadian model offers more than a national success story—it provides a globally relevant roadmap for embedding leadership and governance mechanisms that support socially accountable education. Table 1 explains how medical schools in Canada operationalize their core roles in advancing SA in Medical Education.

Box 1. How Leadership Drives SA in Medical Education

- *Selecting the right person:* The right person in the right place is essential for leadership actions and for considering society's health needs.
- *Defining a Clear Vision:* Leaders articulate strategic visions aligned with community health needs, guiding institutional priorities and motivating collective action.
- *Mobilizing Stakeholders:* Engaging faculty, students, communities, and policymakers ensures inclusive decision-making and shared responsibility.
- *Building Strong Partnerships:* Collaborations with local organizations enhance program relevance, resource sharing, and sustainability of initiatives.
- *Creating a Socially Accountable Learning Environment:* Embedding community engagement and interprofessional education into curricula equips students to effectively address real-world health challenges. Institutional investment in inclusive learning structures further supports long-term reform.

4. How leadership drives SA of medical and health professions institutions

Leadership is a foundational determinant of whether medical schools succeed in aligning their missions with societal health needs. Informed by contemporary leadership theory and supported by evidence from practice, this section demonstrates how academic leaders integrate vision, stakeholder engagement, partnerships, educational design, and accountability to advance SA. The following components illustrate this integration (Box 1), each supported by theoretical grounding and detailed institutional examples. The section also introduces the essential leadership practices and institutional mechanisms needed to enable sustainable, systemic change.

SA of medical and health professions institutions is not achieved through ad hoc initiatives but through a coherent leadership and systematic approach grounded in theory and validated through

practice. Strategic vision guides long-term priorities; inclusive stakeholder engagement enhances relevance; intersectoral partnerships extend institutional capacity; learning environments shape professional identity; and accountability systems ensure responsiveness and transparency [37]. These leadership attributes transform medical schools into institutions that contribute meaningfully to equitable, community-centered health systems. Effective leadership is vital for integrating SA into medical education by setting a clear vision, mobilizing stakeholders, building partnerships, fostering a learning environment, and ensuring accountability. When these functions are embedded into institutional structures and governance systems, they can support continuity and minimize reliance on individual champions.

Box 1 summarizes how leadership drives SA in medical education.

4.1. Strategic vision setting

Leadership rooted in strategic management theory emphasizes the importance of clearly defining institutional goals that reflect the needs of the community. A coherent vision offers direction, mobilizes institutional energy, and aligns internal processes toward social responsiveness. Such vision-setting must be iterative, co-designed with community input, and reflected in planning documents and performance benchmarks.

For instance, at the University of Gezira Faculty of Medicine (FMUG), Sudan, founding leadership articulated a vision of integrating community-based education throughout the curriculum [38]. This vision translated into a curriculum where students spend significant time in rural communities, working on real-world public health challenges. The vision influenced course content and shaped admissions, graduate deployment policies, and research priorities to meet national health system gaps.

4.2. Stakeholder and interest-holder engagement

SA necessitates inclusive structures allowing all stakeholders and Interest-Holder Engagement to shape institutional priorities. For example, in France In the Region du Center et du Val de Loire, the dean of the medical school in Tours demonstrates strategic and inclusive leadership by positioning the institution as a partner in regional health development [35]. He regularly brings together diverse stakeholders—citizens, health authorities, local officials, and professional associations—on campus to engage in open dialogue focused on aligning the school's mission with community needs. By asking the direct question, 'What can and should the

medical school do for you?' the dean initiates a shared agenda for action and ensures institutional responsiveness. His leadership extends beyond convening discussions; he follows through with mechanisms for accountability and progress tracking. The use of community advisory boards, institutional forums, and learner feedback systems are essential tools for sustaining this engagement. This approach has led to tangible outcomes, such as the co-creation of community health centers, targeted graduate retention initiatives, and revised task-sharing policies, illustrating how visionary and participatory leadership at the dean level can embed SA into the medical school's core functions and regional partnerships.

4.3. Partnership formation

In socially accountable institutions, partnership formation is a core mechanism for aligning institutional functions with community needs [39]. Effective partnership formation involves engaging diverse stakeholders in shared governance, redistributing decision-making power, and establishing joint accountability structures. Through these processes, institutional priorities are co-constructed with communities, ensuring relevance, responsiveness, and sustainability. For instance, at the Ateneo de Zamboanga University School of Medicine (ADZU-SOM), Philippines, institutional leadership developed long-standing partnerships with the Department of Health, local government units, and grassroots health workers [40]. These partnerships co-produce community-based projects such as maternal health campaigns and sanitation education programs. Clinical rotations occur within these partner communities, ensuring students engage with real-world system challenges and population health dynamics [23]. Institutional structures such as partnership coordination offices or intersectoral working groups help ensure these relationships are strategic, reciprocal, and enduring.

4.4. Learning environment design and organizational learning

Organizational learning theory suggests that institutions evolve through reflective practices and adaptive programs. A socially accountable learning environment integrates community engagement, interprofessional collaboration, and public health frameworks into educational processes [3,41].

For example, the Nelson R. Mandela School of Medicine (NRMSM), South Africa, restructured its curriculum to embed early exposure to underserved communities through its 'Making a Difference' (MaD) module [42]. Students spend their first year participating in community-based health assessments and

service-learning projects in low-resource clinics. The curriculum emphasizes public health, primary care, social determinants of health, and ethical decision-making [13]. To sustain this model, faculty development, institutional incentives, and recognition mechanisms are essential to enable educators to deliver socially accountable education effectively.

5. Leadership models that promote SA in medical education

Advancing SA in medical education requires leadership that is intentional, inclusive, and strategically aligned with community health priorities. Traditional top-down leadership approaches are insufficient to meet SA's dynamic, values-driven, and context-sensitive demands. Instead, leadership models emphasizing shared vision, responsiveness, service, and collaboration are far better suited to this mission. Transformational, adaptive, servant, and collaborative leadership are the most relevant and practically applicable models. Each model contributes distinct strengths that, when supported by institutional structures and frameworks, can drive and sustain system-level change.

5.1. Transformational leadership

Transformational (vs. transactional) leadership is rooted in vision, inspiration, and systemic change [43]. In socially accountable medical schools, transformational leaders create a compelling narrative that links education and research to community health and social justice. They motivate institutional stakeholders to move beyond routine functions and embrace a shared mission focused on equity and public good. They play a crucial role in aligning diverse stakeholders around a common social vision. By framing curriculum reform as a means of improving health equity or positioning institutional research to address local disparities, transformational leaders inspire policy makers, health providers, and communities to co-invest in institutional goals. Their work shifts stakeholder engagement from symbolic consultation to strategic co-leadership. Transformational leadership also benefits from being embedded within governance processes, ensuring that institutional goals remain aligned with social missions over time [44].

5.1.1. Case study 1: Northern Ontario School of Medicine (NOSM), Canada. Transformative leadership and governance for regional health equity

Canada's Northern Ontario School of Medicine University (NOSM U) demonstrates how transformative leadership can embed SA within a school's core functions in education and research activities. NOSM U programs were initially co-designed with key health

partners using a Distributed Community Engaged Learning (DCEL) model, allowing students to train across more than 90 rural and remote sites. From day one learners are and continue to be directly involved with the communities they will one day serve. The Universities leadership actively aligns NOSM U's mission, student admissions, and curriculum reform with the healthcare needs of Northern Ontario, prioritizing local student intake and rural physician retention. More recently in 2021 NOSM U launched the Center for Social Accountability (renamed the Dr Gilles Arcand Center for Health Equity in 2024) to serve as the catalyst for socially accountable research within NOSM U and across Northern Ontario. Through an embedded research network model, the Center is home to 10 research networks that are all responding to priority health issues. The model supports researchers embedded within the health system and connected through research networks. In addition to networks, the Arcand Center is helping to identify and support critical research data infrastructure for NOSM U. For example, the Center is home to HEWIS (the educational and workforce dataset for NOSM) and NORTHH (the primary care dataset for Northern Ontario), which serve to enable the university to measure its social impact. These activities reflect a governance and leadership model that sees communities as equal partners in education and research [45].

5.2. Adaptive leadership

Adaptive leadership emphasizes flexibility, learning, and co-creation in complex and changing environments [14]. This model is particularly relevant in navigating the tensions and uncertainties that often arise in multi-stakeholder settings. Adaptive leaders recognize that SA challenges are rarely technical—they are adaptive, requiring new thinking, realignment of values, and shifts in power dynamics.

Adaptive leaders facilitate cross-level dialogue—micro (community), meso (regional), and macro (policy/national)—helping partners jointly interpret health data, identify emergent needs, and design context-responsive strategies. Whether reconfiguring student placements during a public health emergency or adjusting policies based on community feedback, adaptive leaders guide institutions through iterative learning cycles that prioritize relevance and resilience. By applying adaptive leadership principles, schools can manage resistance to change, build trust, and gradually shift organizational culture toward greater social accountability. Leadership development programs should incorporate these principles into training, mentoring, and evaluation frameworks.

5.2.1. Case study 2: University of Gezira faculty of medicine (FMUG), Sudan adaptive leadership for holistic, community-responsive medical education

At the University of Gezira, leadership adopted an adaptive approach to medical education, embedding responsiveness, collaboration, and systems thinking at the core of institutional design. Under the guidance of Professor Bashir Hamad, the founding Dean, FMUG integrated community-based education (CBE) into every course from the outset, aligning academic learning with real-world health priorities [38].

Rather than following a fixed model, FMUG continuously revised its curriculum through feedback from communities, students, and health system partners. Governance structures fostered collaboration with state ministry of health authorities, enabling joint planning, policy alignment, and shared accountability. Graduate deployment focused on underserved rural areas, while formal community partnerships ensured ongoing responsiveness to emerging health needs. This approach allowed FMUG to remain relevant, equitable, and resilient in a changing environment.

5.3. Servant leadership

Servant leadership inverts traditional hierarchies by placing the needs of the most vulnerable at the center of leadership practice [46]. This model resonates deeply with the ethical core of SA: that medical education should serve communities, not institutional prestige or self-interest.

In operational terms, servant leaders empower marginalized voices—including Indigenous communities, rural populations, and historically excluded groups—by ensuring they have genuine influence over curricula, research priorities, and governance [30]. Servant leadership enhances citizen engagement, not as token representatives, but as co-creators of educational and service agendas. This leadership style is essential in rebuilding trust and ensuring that SA is grounded in community-defined priorities. When supported by distributed leadership structures and mechanisms for shared governance, servant leadership can help ensure long-term commitment to social responsibility across all levels of the institution.

5.3.1. Case study 3: Ateneo de zamboanga university School of medicine (ADZU-SOM), Philippines servant leadership for community-driven medical education

ADZU-SOM was founded to address physician shortages in underserved areas of the Zamboanga Peninsula. Guided by servant leadership, the school prioritized the needs of the community by recruiting local students and embedding training in real-world settings

[23]. Faculty initially taught without pay, modeling selfless service and commitment to social justice.

The curriculum integrates cultural sensitivity, community health, and public service through a 'sandwich model' of classroom and community rotations. A dual MD-MPH program prepares graduates to lead in both clinical and public health roles. Strong partnerships with local health authorities ensure co-designed, sustainable initiatives. High regional physician retention reflects the deep impact of values-driven, community-first leadership.

5.4. Collaborative leadership

Collaborative leadership centers on partnership, shared governance, and distributed authority [47]. SA, by definition, demands a whole-of-society response to health challenges. No single institution or actor can address complex health inequities alone. Collaborative leaders excel at creating inclusive structures—multi-stakeholder committees, advisory boards, or cross-sector platforms—that allow partners to jointly set priorities, allocate resources, and measure outcomes.

Collaborative leadership ensures that each partner—from academia to policy makers to industry—is not only heard but engaged in a coordinated way. It enables the creation of feedback loops where data becomes shared knowledge, knowledge becomes collective wisdom, and wisdom drives action. This leadership model is particularly important for sustaining long-term, scalable impact across community, regional, and national systems.

5.4.1. Case study 4 flinders University School of Medicine, Australia Collaborative leadership for rural and remote health equity

Flinders University's Parallel Rural Community Curriculum (PRCC) exemplifies collaborative leadership by engaging rural communities, health services, and academic staff in shared decision-making. The program places medical students in rural communities for a full academic year, where they live, learn, and work closely with local clinicians and residents. Leadership at Flinders fostered strong partnerships with rural general practices, local health authorities, and community organizations. Curriculum content, placement logistics, and student support systems were co-designed with these stakeholders to ensure mutual benefit, cultural relevance, and continuity. This collaborative model empowered local clinicians as co-educators and gave communities a voice in shaping future healthcare professionals. The result has been enhanced student learning, stronger community-university relationships, and improved

rural workforce outcomes, with a significant number of graduates returning to practice in rural areas [48].

While each leadership model brings distinct advantages, effective SA advancement requires strategic integration. A transformational leader may adopt adaptive strategies to navigate complexity, practice servant leadership to center marginalized communities, and build durable, cross-sector partnerships collaboratively. At the micro level, leaders facilitate community-driven decisions shaping educational content and service delivery. At the meso level, they coordinate and align institutional and regional stakeholders to operationalize socially accountable practices. At the macro level, leadership involves championing systemic changes—such as policy reforms and funding models—that embed SA into the core mission of medical education. Embedding leadership development within this integrated framework equips medical schools to become drivers of responsive, equitable health systems. In this context, leadership is both an individual skillset and a collective institutional function—capable of converting social values into measurable outcomes and transforming stakeholder collaboration into sustained systemic change.

6. How leaders operationalize SA

The advancement of SA in medical education depends not only on institutional mission statements or strategic plans, but fundamentally on the capabilities and attributes of those entrusted with leadership. Effective leadership is the engine that drives and sustains socially accountable transformation. It must be intentional, evidence-informed, and grounded in values that prioritize health equity, community responsiveness, and ethical service. The transformation toward a socially accountable institution is not accidental—it requires leaders who possess specific competencies that enable them to mobilize engagement, translate vision into action, and integrate SA principles across education, research, and service. Strategic vision ensures direction; ethical integrity fosters trust; collaboration enhances relevance; adaptability supports innovation; cultural humility promotes inclusion; communication builds consensus; and mentorship ensures continuity [49]. These leadership qualities are not aspirational but observable, teachable, and necessary. When anchored and reinforced through practice, they empower medical and health professions schools to embed socially accountable practices that advance equity, improve population health outcomes, and respond to the real-world needs of communities. Under such leadership, medical institutions are transformed from traditional training centers into dynamic, socially engaged agents of systemic change. Box 2 summarizes how leaders can

Box 2. Essential Leadership Qualities for SA in Medical Education drawn from [5].

- *Strategic Vision*: Ability to anticipate community health needs and align institutional goals accordingly, fostering proactive innovation.
- *Ethical Integrity*: Ability to ensure decisions are transparent, fair, and consistently aimed at community benefit, establishing trust and accountability.
- *Collaborative Spirit*: Actively engages diverse stakeholders through shared decision-making to ensure comprehensive, community-responsive solutions.
- *Adaptive and Innovative*: Ability to be flexible and open toward adopting new technologies and methods to address evolving healthcare challenges effectively.
- *Humility and Reflexivity*: Actively participates and creates a culture where all voices can be heard, and where inclusive healthcare and educational initiatives are valued.
- *Effective Communicator*: Clearly articulating goals, progress, and successes to build consensus and foster continuous engagement among stakeholders.
- *Effective Mentors and Capacity Builder*: Ability to develop future leaders through structured mentorship and professional growth opportunities, ensuring continuity in SA efforts.
- *Data and Evidence Driven*: Ability to collect, analyze, and apply data systematically to guide decisions, evaluate outcomes, and ensure accountability for social impact.
- *Disciplined*: Consistently maintains focus, follows through on commitments, upholds standards, and ensures sustained progress toward social accountability objectives.

operationalize SA in medical schools through distinct qualities that enable transformative and sustainable change.

7. Practical steps to operationalize leadership for social accountability

To translate these leadership qualities into practice, institutions must adopt a structured and intentional approach to implementation. Leadership for social accountability is not abstract, it requires specific, visible actions that align institutional structures, culture, and daily operations with community health priorities. Practical steps include establishing inclusive governance mechanisms, embedding social accountability into curriculum and policy, investing in leadership development, and building sustained community partnerships. Embedding social accountability into curriculum and assessment involves more than adding community placements or service-learning components. It requires aligning learning outcomes with population health needs, integrating social determinants of health into foundational courses, and using assessment tools that measure students' ability to engage with communities ethically, respectfully, and effectively [6]. For example, Objective Structured Clinical Examinations (OSCEs) can include stations on equity-based communication, cultural humility, or navigating structural barriers to

Box 3. Practical Steps to Operationalize Leadership for Social Accountability

- *Align Vision and Mission:* Ensure the institution's mission explicitly reflects a commitment to health equity and social accountability.
- *Conduct Participatory Needs Assessments:* Engage communities, learners, and local health authorities to identify shared priorities and guide strategic planning.
- *Establish a Social Accountability Committee:* Create a multidisciplinary committee, including community representatives, to oversee, coordinate, and evaluate SA initiatives.
- *Invest in Leadership Development:* Implement faculty development programs focused on adaptive, collaborative, and servant leadership to build institutional capacity.
- *Strengthen Community Partnerships:* Formalize relationships with public agencies, health systems, and civil society to co-design programs and ensure shared ownership.
- *Embed SA in Curriculum and Assessment:* Integrate community-based education, public health competencies, and social justice themes across all phases of training.
- *Monitor and Evaluate Impact:* Establish robust systems to track graduate outcomes, community health indicators, and institutional responsiveness.
- *Foster a Culture of Feedback and Reflection:* Create safe spaces for learners, staff, and communities to reflect, provide input, and shape ongoing improvement.
- *Recognize and Reward Engagement:* Incorporate social accountability contributions into faculty promotion, student recognition, and institutional benchmarking.
- *Communicate and Disseminate Results:* Share progress transparently with internal and external stakeholders to reinforce trust, learning, and sustained commitment.
- *Establish SA Research Culture:* Fosters evidence-based social accountability practices and drives continuous institutional development. It will become a practical mechanism to embed and operationalize social accountability across health professions education.

care. Portfolios and reflective assignments can document how students apply social accountability principles during community-based rotations or interprofessional projects. Curriculum mapping tools can help ensure that SA values are vertically and horizontally integrated across the years of training.

Establishing a research culture grounded in SA requires defining institutional research priorities that reflect real-world challenges and health inequities. Institutions can support this by creating dedicated SA research units, funding community-partnered research, and promoting faculty development in participatory and implementation research methods. Incentives such as seed grants, publication support, and research recognition awards can encourage faculty and students to pursue socially relevant topics. Collaborations with ministries of health, local NGOs, and civil society groups also ensure that research questions are co-developed and findings are used to inform action. Embedding SA indicators into research performance frameworks helps shift the culture from quantity to relevance and impact. These steps must be context-sensitive, continuously evaluated, and co-

owned by institutional and community stakeholders.

Box 3 outlines key implementation actions that leaders can take to embed social accountability across education, research, and service functions.

8. Conclusion

Leadership is the driving force that turns SA from mere aspiration into an established reality. When rooted in strategic vision, ethical commitment, and inclusive engagement, leadership advances curriculum reform, research relevance, and community partnerships aligned with societal health needs. This guide has outlined how various leadership models—transformational, adaptive, servant, and collaborative—can be utilized to embed SA into the fundamental functions of health professions education. By investing in leadership development, aligning structures with mission, and fostering accountability, institutions can achieve sustainable, equitable change. The future of socially accountable education relies not just on good intentions but on effective, value-driven leadership at every level.

8.1. Glossary

- **Social Accountability (SA):** The obligation of medical and health professions education institutions to align their education, research, and service activities with the priority health needs of the communities, regions, or nations they serve, particularly those underserved or marginalized. It involves measurable outcomes that demonstrate responsiveness to societal health challenges.
- **Leadership in Social Accountability in Medical Education:** The intentional, values-based process through which individuals in formal or informal roles influence, mobilize, and guide institutional and community stakeholders to embed social accountability across all functions of a medical or health professions school.
- **Change Management:** A structured, evidence-informed approach to guiding individuals, teams, and institutions through a transition from the current state to a desired, improved future state. It includes planning, implementation, and adaptation strategies to achieve sustainable transformation while addressing resistance and fostering commitment.
- **Distributed Education:** An educational model where learning activities occur across multiple sites—often in rural or underserved areas—bringing education closer to communities, fostering contextual learning, and enhancing social accountability.

- **Cultural Humility:** A mindset focused on acknowledging one's own biases and limitations while remaining open to learning about and respecting other cultures that underlies the ability of individuals and institutions to understand, respect, and effectively respond to cultural and social diversity in ways that enhance relevance, inclusion, and equity in education, research, and service.
- **Collaborative Leadership:** A leadership style that emphasizes shared power, inclusiveness, and partnership among diverse stakeholders, promoting collective ownership, co-creation, and consensus-driven decision-making in institutional change processes.
- **Servant Leadership:** A leadership style centered on serving others—particularly the needs of students, faculty, and communities—by fostering empowerment, humility, empathy, and social responsibility.
- **Adaptive Leadership:** A leadership style that focuses on navigating complex, evolving challenges through learning, flexibility, and distributed problem-solving, particularly in uncertain or resource-constrained environments.
- **Institutional Transformation:** A systemic and sustained shift in an institution's structures, values, operations, and culture to better align with its social accountability mandate and improve its responsiveness to community health needs.

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References

1. Boelen C, Heck J. Defining and measuring social accountability of medical schools. Vol. WHO/HRH/95. Geneva: World Health Organization; 1995. doi: 10.3109/0142159X.2013.770134
2. Dharamsi S, Ho A, Spadafora SM, et al. The physician as health advocate: translating the quest for social responsibility into medical education and practice. *Acad Med*. 2011;86(9):1108–1113. doi: 10.1097/ACM.0b013e318226b43b
3. Wood B, Fitzgerald M, Kendall C, et al. Integrating socially accountable health professional education and learning health systems to transform community health and health systems. *Learn Health Syst*. 2021; 5(3):e10277. doi: 10.1002/lrh.210277

4. Dash NR, Taha MH, Shorbagi S, et al. Evaluation of the integration of social accountability values into medical education using a problem-based learning curriculum. *BMC Med Educ.* 2022;22(1):181. doi: [10.1186/s12909-022-03245-6](https://doi.org/10.1186/s12909-022-03245-6)
5. Boelen C, David Pearson A, Kaufman J, et al. Producing a socially accountable medical school: AMEE Guide No. 109. *Med Teach.* 2016;38(11):1078–1091. doi: [10.1080/0142159X.2016.1219029](https://doi.org/10.1080/0142159X.2016.1219029)
6. Abdalla ME, Taha MH, Onchonga D, et al. Instilling social accountability into the health professions education curriculum with international case studies: AMEE Guide No. 175. *Med Teach.* 2025a;47(7):1083–1096. doi: [10.1080/0142159X.2024.2412098](https://doi.org/10.1080/0142159X.2024.2412098)
7. Haldane V, De Foo C, Abdalla SM, et al. Health systems resilience in managing the COVID-19 pandemic: lessons from 28 countries. *Nat Med.* 2021;27(6):964–980. doi: [10.1038/s41591-021-01381-y](https://doi.org/10.1038/s41591-021-01381-y)
8. Wang H, Waldman DA, Zhang H. Strategic leadership across cultures: current findings and future research directions. *J World Bus.* 2012;47(4):571–580. doi: [10.1016/j.jwb.2012.01.010](https://doi.org/10.1016/j.jwb.2012.01.010)
9. Boelen C. Coordinating medical education and health care systems: the power of the social accountability approach. *Med Educ.* 2018;52(1):96–102. doi: [10.1111/medu.13394](https://doi.org/10.1111/medu.13394)
10. McKimm J, McLean M. Rethinking health professions' education leadership: developing 'eco-ethical' leaders for a more sustainable world and future. *Med Teach.* 2020;42(8):855–860. doi: [10.1080/0142159X.2020.1748877](https://doi.org/10.1080/0142159X.2020.1748877)
11. Yahaya R, Ebrahim F. Leadership styles and organizational commitment: literature review. *J Manage Dev.* 2016;35(2):190–216. doi: [10.1108/JMD-01-2015-0004](https://doi.org/10.1108/JMD-01-2015-0004)
12. Valsangkar B, Chen C, Wohltjen H, et al. Do medical school mission statements align with the nation's health care needs? *Acad Med.* 2014;89(6):892–895. doi: [10.1097/ACM.0000000000000241](https://doi.org/10.1097/ACM.0000000000000241)
13. Abdalla ME, Taha MH, Onchonga D, et al. Integrating the social determinants of health into curriculum: AMEE Guide No. 162. *Med Teach.* 2025b;46(3):304–316. doi: [10.1080/0142159X.2023.2254920](https://doi.org/10.1080/0142159X.2023.2254920)
14. McKimm J, Ramani S, Forrest K, et al. Adaptive leadership during challenging times: effective strategies for health professions educators: AMEE Guide No. 148. *Med Teach.* 2023;45(2):128–138. doi: [10.1080/0142159X.2022.2057288](https://doi.org/10.1080/0142159X.2022.2057288)
15. Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet.* 2010;376(9756):1923–1958. doi: [10.1016/S0140-6736\(10\)61854-5](https://doi.org/10.1016/S0140-6736(10)61854-5)
16. Kezar A, Carducci R. Revolutionizing leadership development: lessons from research and theory. In: Adrianna J. Kezar (ed.), *Rethinking leadership in a complex, multicultural, and global environment*. Routledge; 2023. pp. 1–38.
17. Hayat DZ. Catalysing change: the power of effective leadership in driving innovation. *Educ Adm: Theory Pract.* 2024;30(5):3789–3793. doi: [10.53555/kuey.v30i5.3534](https://doi.org/10.53555/kuey.v30i5.3534)
18. Botha GC, Crafford L. From understanding to action: a juncture-factor framework for advancing social responsiveness in health professions education. *Front Med (Lausanne).* 2024;11:1435472. doi: [10.3389/fmed.2024.1435472](https://doi.org/10.3389/fmed.2024.1435472)
19. Ross BM. The socially accountable professor in higher education. *J Educ Learn.* 2018;7(5):181–187. doi: [10.5539/jel.v7n5p181](https://doi.org/10.5539/jel.v7n5p181)
20. Bohlens C. Governance and leadership: driving change in higher education. In: Mustafa Kayyali (ed.), *Building organizational capacity and strategic management in academia*. IGI Global; 2025. pp. 269–306.
21. Bainbridge L, Grossman S, Dharamsi S, et al. Engagement studios: students and communities working to address the determinants of health. *Educ Health (Abingdon).* 2014;27(1):78–82. doi: [10.4103/1357-6283.134330](https://doi.org/10.4103/1357-6283.134330)
22. Markham R, Hunt M, Woollard R, et al. Addressing rural and indigenous health inequities in Canada through socially accountable health partnerships. *BMJ Open.* 2021;11(11):e048053. doi: [10.1136/bmjopen-2020-048053](https://doi.org/10.1136/bmjopen-2020-048053)
23. Guignona M, Halili S, Cristobal F, et al. A curriculum for achieving Universal Health Care: a case study of Ateneo de Zamboanga University School of Medicine. *Front Public Health.* 2021;9:612035. doi: [10.3389/fpubh.2021.612035](https://doi.org/10.3389/fpubh.2021.612035)
24. Fongwa S. Universities as anchor institutions in place-based development: implications for south African universities engagement. *S Afr J Higher Educ.* 2023;37(1):92–112.
25. Ellaway RH, Malhi R, Bajaj S, et al. A critical scoping review of the connections between social mission and medical school admissions: BEME Guide No. 47. *Med Teach.* 2018;40(3):219–226. doi: [10.1080/0142159X.2017.1406662](https://doi.org/10.1080/0142159X.2017.1406662)
26. Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. *Med Educ.* 2009;43(9):887–894. doi: [10.1111/j.1365-2923.2009.03413.x](https://doi.org/10.1111/j.1365-2923.2009.03413.x)
27. Rourke J. Social accountability: a framework for medical schools to improve the health of the populations they serve. *Acad Med.* 2018;93(8):1120–1124. doi: [10.1097/ACM.0000000000002239](https://doi.org/10.1097/ACM.0000000000002239)
28. Abdalla M, Taha M, Wadi M, et al. What makes a medical school socially accountable? A qualitative thematic review of the evaluation of social accountability of medical schools in the Eastern Mediterranean Region. 2022.
29. Boelen C, Dharamsi S, Gibbs T. The social accountability of medical schools and its indicators. *Educ Health (Abingdon).* 2012;25(3):180–194. doi: [10.4103/1357-6283.109785](https://doi.org/10.4103/1357-6283.109785)
30. Mian O, Hogenbirk JC, Marsh DC, et al. Tracking indigenous applicants through the admissions process of a socially accountable medical school. *Acad Med.* 2019;94(8):1211–1219. doi: [10.1097/ACM.00000000000002636](https://doi.org/10.1097/ACM.00000000000002636)
31. Ventres W, Kravitz JD, Dharamsi S. PEARLS+: connecting societal forces, social determinants, and health outcomes. *Acad Med.* 2018;93(1):143–143. doi: [10.1097/ACM.0000000000002012](https://doi.org/10.1097/ACM.0000000000002012)
32. Walling E, Lachance E, Yeo L, et al. Key drivers of social accountability in nine Canadian medical schools. *Med Teach.* 2021;43(2):182–188. doi: [10.1080/0142159X.2020.1832205](https://doi.org/10.1080/0142159X.2020.1832205)
33. Wood B, Bohonis H, Ross B, et al. Comparing and using prominent social accountability frameworks in medical education: moving from theory to implementation in Northern Ontario, Canada. *Can Med Educ J.* 2022;13(5):45–68. doi: [10.36834/cmej.73051](https://doi.org/10.36834/cmej.73051)

34. Barber C, Chahine S, Leppink J, et al. Global perceptions on social accountability and outcomes: a survey of medical schools. *Teach Learn Med.* 2023;35(5): 527–536. doi: [10.1080/10401334.2022.2103815](https://doi.org/10.1080/10401334.2022.2103815)
35. Boelen C. Why should social accountability be a benchmark for excellence in medical education? *Educación Médica.* 2016;17(3):101–105. doi: [10.1016/j.edumed.2016.06.004](https://doi.org/10.1016/j.edumed.2016.06.004)
36. The Steering Committee on Social Accountability of Medical Schools in Canada. Social accountability: a vision for Canadian medical schools. Health Canada; 2001. https://www.afmc.ca/wp-content/uploads/2022/10/sa_vision_canadian_medical_schools_en.pdf.
37. Kayyali M. A practical guide to strategic planning in higher education. In: Mustafa Kayyali (ed.), *Building organizational capacity and strategic management in academia*. IGI Global; 2025. pp. 1–34.
38. Hamad B. Community-oriented medical education: what is it. *Med Educ.* 1991;25(1):16–22. ?doi: [10.1111/j.1365-2923.1991.tb00021.x](https://doi.org/10.1111/j.1365-2923.1991.tb00021.x)
39. Markham R, Graham S, Hunt M, et al. Social accountability in practice: breathing and weaving together to build relationships and transform rural health services. *Soc Innov J.* 2022;14.
40. Halili S, Jr, 'Ben F, Cristobal T, et al. Addressing health workforce inequities in the Mindanao regions of the Philippines: tracer study of graduates from a socially-accountable, community-engaged medical school and graduates from a conventional medical school. *Med Teach.* 2017;39(8):859–865. ' doi: [10.1080/0142159X.2017.1331035](https://doi.org/10.1080/0142159X.2017.1331035)
41. Peck K, Furze J, Black L, et al. Interprofessional collaboration and social responsibility: utilizing community engagement to assess faculty and student perception. *Int J Interdiscipl Soc Sci.* 2010;5(8):205–222.
42. Saloojee S, Van Wyk J. A problem-based learning curriculum and undergraduate performance in the final psychiatry examination at the Nelson R Mandela school of medicine. *S Afr J Psych.* 2013; 19(4):4. doi: [10.4102/sajpsychiatry.v19i4.437](https://doi.org/10.4102/sajpsychiatry.v19i4.437)
43. Givens RJ. Transformational leadership: the impact on organizational and personal outcomes. *Emerging Leadership Journeys.* 2008;1(1):4–24.
44. Strahan E. Nothing ordinary: the story of the northern ontario school of medicine. *Fam Med.* 2022; 54(9):740–741. doi: [10.22454/FamMed.2022.434022](https://doi.org/10.22454/FamMed.2022.434022)
45. Strasser R, Hogenbirk J, Jacklin K, et al. Community engagement: a central feature of NOSM's socially accountable distributed medical education. *Can Med Educ J.* 2018;9(1):e33–e43. doi: [10.36834/cmej.42151](https://doi.org/10.36834/cmej.42151)
46. Dennis RS, Kinzler-Norheim L, Bocarnea M. Servant leadership theory: development of the servant leadership assessment instrument. In: *Servant leadership: developments in theory and research*. Springer; 2010. pp. 169–179.
47. Nelson T, Squires V. Addressing complex challenges through adaptive leadership: a promising approach to collaborative problem solving. *J Leadership Educ.* 2017;16(4):111–123. doi: [10.12806/V16/I4/T2](https://doi.org/10.12806/V16/I4/T2)
48. Couper I, Worley PS, Strasser R. Rural longitudinal integrated clerkships: lessons from two programs on different continents. *Rural Remote Health.* 2011; 11(1):226–236. doi: [10.22605/RRH1665](https://doi.org/10.22605/RRH1665)
49. Candrasari R, Yorman Y, Mayasari N, et al. Visionary leadership in education management: leading toward optimal achievement in the era of independent learning. *Indonesian J Educ.* 2023;3(3):451–467.