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Teaching compassion for social accountability: A parallaxic investigation

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ABSTRACT

Background: In an arts integrated interdisciplinary study set to investigate ways to improve social accountability (SA) in medical education, our research team has established a renewed understanding of compassion in the current SA movement.
Aim: This paper explores the co-evolution of compassion and SA.
Methods: The study used an arts integrated approach to investigate people's perceptions of SA in four medical schools across Australia, Canada, and the USA. Each school engaged approximately 25 participants who partook in workshops and in-depth interviews.
Results: We began with a study of SA and the topic of compassion emerged out of our qualitative data and biweekly meetings within the research team. Content analysis of the data and pedagogical discussion brought us to realize the importance of compassion in the practice of SA.
Conclusions: The cultivation of compassion needs to play a significant role in a socially accountable medical educational system. Medical schools as educational institutions may operate themselves with compassion as a driving force in engaging partnership with students and communities. Social accountability without compassion is not SA; compassion humanizes institutional policy by engaging sympathy and care.

KEYWORDS
Education environment; ethics/attitudes; medical education; social accountability

Introduction

By convention, compassion is one of the defining characteristics of a good physician. The first principle of medical ethics in the American Medical Association's Code of Medical Ethics states that 'A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights' (American Medical Association 2016, 2022). The Canadian Medical Association puts compassion on top of its list of 'virtues exemplified by the ethical physician' (Canadian Medical Association 2018). The Medical Board of Australia's revised code indicates that physicians should 'display qualities such as integrity, truthfulness, dependability and compassion' (Medical Board of Australia 2020). While compassion is a conventional ethical virtue, social accountability (SA) appears as a newer idea that emerged around the latter part of the twentieth century, reinforced by numerous defining documents. They include the Edinburgh Declaration (World Federation for Medical Education (World Federation for Medical Education (WFME) 2021) 1988), the 2010 Global Consensus on Social Accountability (published in Boelen 2011), and the Tunis Declaration at the World Summit on Social Accountability (Network-Towards Unity for Health (TUFH) 2017). It is also now a Canadian Medical School accreditation standard (CACMS 2019) with a global movement toward being embedded in other health professional schools worldwide.

Practice points

- Social accountability (SA) and compassion may seem to be two vastly distanced concepts, but they are indeed closely co-evolved.
- Social accountability on its own may sound institutional or may be perceived as a bureaucratic checkbox, while compassion may be misunderstood as an individual characteristic that we seek in medical school applicants.
- Compassion, however, is unlike sympathy and empathy; the term infers taking action to ease suffering.
- Social accountability at its best associates with social justices, the strife for equality and equity by listening and making changes to meet the needs of the communities.
- Compassion humanizes institutional policy by engaging sympathy and care.

As defined by the World Health Organization (WHO) in 1995, SA refers to the obligation of medical schools 'to direct education, research and service activities towards addressing the priority health concerns of the community,

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region, and/or nation they have a mandate to serve' (Boelen and Heck 1995, p. 3). To achieve this goal, WHO urges medical schools to address priority health concerns 'identified jointly by governments, health care organizations, health professionals and the public' (Boelen and Heck 1995, p. 3). In response, many medical schools currently identify SA as a priority and the Committee on Accreditation Canadian Medical Schools (CACMS 2019; https://cacms-cafmc.ca/) has a specific standard for SA. While SA is not explicitly named in Australian medical school accreditation standards, one of the four domains in the version published in 2012 is 'health and society: the medical graduate as a health advocate' (Australian Medical School Accreditation Committee 2012, p. 1). Administratively, a number of medical schools engaged in a transnational Australia and New Zealand in 2014 by utilizing Training for Health Equity Network's (THEnet). Later they 'established a Social Accountability Committee to consider the contemporary challenges Australian, New Zealand and other Pacific Island region medical schools face to produce the kind of doctors required by evolving health systems, and to respond to the critical health concerns of society' (Medical Deans 2022). Of course, the demand for SA can also come from medical students and communities, but the connotations of SA (as opposed to compassion) associate more with institutional and social domains.

At first glance, compassion and SA cover different ground; compassion is a human characteristic that we seek in physicians, whereas SA is a value that is sometimes formalized as an institutional obligation. As medical schools seek the former in recruitment while engaging the latter in teaching and research, the two concepts cross paths when medical students enter their communities to address priority health concerns.

Our study began with an arts integrated approach to investigate people's perceptions of SA in four medical schools across Canada, Australia, and the USA. As the topic of compassion emerged out of our qualitative data and biweekly discussion within the research team, we formed a Compassion Writing Group to develop a biological–historical–anthropological framework for the interpretation of the data.

Methodology: the parallaxic praxis framework and arts integrated research

The idea of exploring the interrelationship between SA and compassion emerged as part of a larger study of SA funded by the Social Sciences and Humanities Research Council of Canada. Our project, Stories and Art of Local Transformation in Health Education (SALT-HE), aimed to deepen the understanding of how socially accountable education fosters and narrates global and local transformation in health systems as depicted by visual representations and narrated stories.

SALT-HE was initiated by researchers associated with the Northern Ontario School of Medicine (NOSM) (Thunder Bay and Sudbury, Ontario, Canada). The core team of the project was composed of researchers associated with the Canadian Social Accountability Network (Memorial University of Newfoundland, St. John's, Newfoundland (MUN)), the Department of Family & Community Medicine at the University of New Mexico School of Medicine (UNM) in Albuquerque, New Mexico, USA, and School of Medicine and Dentistry, James Cook University (JCU), Townsville, Queensland, Australia). Once funded, the project began with an advisory group that guided the study and molded the core team. The study objectives were twofold: (1) to explore the values and meanings of SA across different medical schools; (2) to identify the lived and embodied practices of SA within different health systems. The team sought better understandings of how to improve SA in medical education and, in particular, foster transformation within rural health systems.

The key part of the study involved arts integrated workshops. Between 2020 and 2021, arts integrated workshops were conducted in all four schools to collect insights from various perspectives on SA. Through media and networks, we recruited participants to represent a diverse range of viewpoints: there were leaders of medical education, professionals and students in various health fields. The JCU team wanted to explore the impact of curriculum and placement experiences on the understanding of SA, so participants were medical students and faculty members who had these insider perspectives. The other three schools also interviewed community members who were not working in the healthcare sectors. The recruitments were advertised mainly through public media and internal communiques of the associated medical schools, but there were also cases of referral. We used convenience sampling in that we accepted any participant over 18 years of age who volunteered, and we capped participants at 25 in each of the four sites. Nevertheless, by ways of advertising and referral, the Canadian and the US schools included the five groups of the 'Partnership Pentagram' identified by WHO for partnership in health development: health administrators, policy makers, health professionals, academia, and communities (Boelen 2000, p. 55; Rourke 2006, p. S46).

The arts-integrated approach (which is also associated with the arts-based method) is a relatively new way to 'illuminate human dimensions of health and illness in ways that help lower disciplinary barriers and improve understanding of both health and social care' (Boydell et al. 2016, p. 3). Arts can help researchers to look into our 'collective stories' in order to find complexity in qualitative interviews and data analysis (Cheu 2017, p. 219). We have engaged artistic and narrative expressions in our core group meetings, workshops, as well as individual and group interviews in order to invite new thinking and deep imagining of SA. We have also employed artists in our knowledge translation phase to create collective artworks that represent our findings beyond conventional intellectual means; one of them, for example, is by Tashya Orasi, used as the cover art of the *Canadian Medical Education Journal* (Vol. 13, No. 3, Orasi 2022).

One reason why the arts can 'integrate' lies in its ability to encourage 'parallaxic praxis.' Pauline Sameshima explains that arts can orchestrate interdisciplinary conversations with multiple (thus 'parallaxic') perspectives in various phases of research: data collection, analysis, and renderings (Sameshima 2019, p. 7–10). The term parallax refers to the notion that what is visible is determined by the positionality of the viewer. In a parallax view, the discrepancies between different positions viewing the same object are valued. As we know in optics, the overlapping images of a parallax produce the information for judging distance and creating three-dimensional vision. A parallaxic framework values and draws attention to the various perspectives of the diverse

stakeholders involved (Sameshima et al. 2019). The members of the team represent a wide range of disciplines – medicine, medical anthropology, education, visual arts, and critical theory.

Our data collection has ethical approval from all four schools. We conducted arts integrated workshop-interviews in small groups or one-on-one. During the workshops, we invited participants to use an art form of their choice to express their views on SA. Due to COVID-19, workshops in Canada and the United States were conducted through video conferencing (while at JCU the meeting was face to face because the site was at a different stage of data collection as pandemic rules changed).

At JCU, where the participants were medical students and faculty members, the questions were more specific. After inviting the participant to describe their art representation, the questions explicitly ask about the connection between personal values, experiences, and perspectives and SA practice. This discussion also prompts the issues of social justice, environmental responsiveness, and human rights.

The North American schools asked similar questions, but less socially and politically explicit in the prompts. The workshop began with a primer to the arts integrated activity. The workshop coordinators then asked participants how they might describe SA and how they might represent their thoughts artistically. There were two questions provided to the participants in the 'Pre-Information Letter':

1. What excites you most about social accountability?
2. What do you fear most about social accountability?

For each participant, we also had follow-up discussions with the participants either by debriefing the participants immediately after the workshop or by arranging separate interviews. In this way, we gain in-depth stories with the complexity of thoughts as well as feelings.

Over 2 years, the core team of SALT-HE met virtually approximately every two weeks for one hour of reflexive practice. These meetings integrated parallaxic praxis into the agenda; they included facilitated reflection, art making, and project updates. All meetings were recorded, transcribed, and analyzed for key themes. Part of the study looked inwards to explore changes within the research team's collective understanding of SA. As the core team included people from many disciplines – medicine, sciences, arts, administration, critical theory, and more – the meetings sometimes included self-study simultaneously as it analyzed the workshops and interviews.

Indeed, the core team came to realize the significance of 'compassion' as a recurring topic in our discussions through our research group activities. As a result, we formed a subgroup to deepen our investigation of SA in relation to compassion. This international, multidisciplinary subgroup became 'the Compassion Writing Group' that composed this paper.

Defining the concepts: standard definition and intermixed usage

To continue our investigation, we will first introduce and clarify the meanings of some key words. The intermixed usage among empathy, sympathy, and compassion in medicine is complex. Many publications in the medical education and practice literature (Graham 2016; Howick 2017; Wright 2019; Sinclair et al. 2021) explore the importance of empathy, sympathy and compassion to enhance patient care and physician well-being. Often, sympathy, empathy and compassion are used interchangeably and frequently conflated in the healthcare literature (Sinclair et al. 2021). These terms sometimes share elements with other forms of prosocial behavior, such as generosity, kindness, and patient centeredness (Jeffrey 2016). Empathy is described as an ability to perceive another person's feelings without losing the perception of separateness. According to Hojat et al. (2001, 2003), crossing the border of separateness involves leaving 'the territory of empathy' and entering into 'the territory of sympathy,' in which sympathy is 'the act or capacity of entering into or joining the feelings of another person' (2001, p. 351).

Compassion

Etymologically, compassion's Latin root 'com' means 'with' and '*pati*' (passion) means 'to suffer': compassion, therefore, literally means 'suffering together with another' (Oxford English Dictionary, full entry, accessed September 25, 2021). The *Oxford English Dictionary* clarifies that the word denotes 'the feeling or emotion, when a person is moved by the suffering or distress of another, and by the desire to relieve it.' Empathy and sympathy are rooted in the Greek word 'pathos,' which refers to feelings. Sympathy (*sumpatheia*) is 'feeling for (*sum*),' while empathy is 'feeling in (em).' Compassion is ecclesiastical Latin from *compati*, referring to 'suffer with,' which is mainly an act (Table 1).

Compassion does not have to be a 'feeling,' but suffering with someone, connoting action and the desire to relieve sufferings. The emotions that an empath can sense may be of any kind, although in everyday usage we normally refer to 'empathy' in times of hardship, suffering, lost, etc. Sympathy (feeling for someone) may be more so used in hard times, yet one can have sympathy for someone and yet do nothing other than expressing that sympathy. It is also more likely for a sympathetic person to take action. Compassion shares much in common with empathy. As the Oxford dictionary notes, compassion may mean empathy, but that etymology is 'obsolete.' In contrast to 'empathy' – which refers to acknowledging emotions affected by others – compassion implies a deeper involvement, including taking action to make a difference. 'Passion' (*pati*) denotes – 'the desire to relieve' – the word associates with the Latin term, *patior* or *passus sum*, which also means, 'to bear' or 'to endure.' It is more specifically about taking up the task of bearing the suffering of others, as used in 'the Passion of Christ.'

A study of 53 palliative care patients by Sinclair et al. (2017) reinforces the etymology by noting the reference to 'compassion' with 'a deep awareness of suffering of another coupled with the wish to relieve it.' Sinclair et al. elaborates that sympathy is described as 'an unwanted, pity-based response' while empathy is acknowledged as

Table 1. Etymological connotations of compassion, empathy and sympathy.

Compassion	Empathy	Sympathy
Action-oriented	Feeling-oriented	Feeling-oriented
Emotion is implied	Action may occur	Action may occur

'an affective response' which leads to 'attempts to understand an individual's suffering through emotional resonance.' Compassion is the most preferred and 'impactful' of the three as it adds features of 'being motivated by love' and 'action' – although the additional features may sometimes appear to be 'small, supererogatory acts of kindness' (p. 437). Consequently, compassion reflects a motivation to help change the other person's experience to be more positive. Putting these concepts together, Hojat et al. (2003) present the notion of 'compassionate detachment' as being used 'to describe the physician's empathic concern for the patient while keeping sympathy at a reasonable distance to maintain an emotional balance' (p. 27). This description is within the Oxford Dictionary's full definition and distinction between compassion and sympathy.

Social accountability

In contrast to the long evolution of compassion, SA is a relatively younger concept. We may trace the discourse back to the Flexner Report of 1910, which, as Thomas Duffy describes, 'transformed the nature and process of medical education in America with a resulting elimination of proprietary schools and the establishment of the biomedical model as the gold standard of medical training' (Duffy 2011, p. 296). However, it is only in principle but not in contemporary terminology that the 1910 Flexner Report (Flexner 1910) relates to 'social accountability' – the Flexner Report's concentration on science education and advocacy for state regulation of medical licensure is based on a principle of accountability. It is unfortunate, however, that the Flexner Model's science-based classroom educational model is in part responsible for the eventual development of a subspecialist-privileged culture in the second half of the twentieth century (Strasser and Strasser 2020, p. 30–31). The need for a renewal of SA for more socially responsive physicians was introduced close to the end of the twentieth century.

We shall call the current 'social accountability' discourse a renewal because the need for the healer to be accountable (or responsible) is as old as the beginning of the profession itself. In Robin Tiger and Lionel Fox's *The Imperial Animal* (Tiger and Fox 1971), the anthropologists posit that physicians are granted privileges by society in return for ensuring the health of society. They describe the 'medicine man' as the first individual differentiated by the early hunter-gatherer human groups to be provided with food and protection in return for healing and restoring the sick to health and full functioning in society. In this context, society places expectations on physicians not only in terms of personal and professional behavior, but also in protecting the health of the wider society. This observation is not to neglect the importance of women as traditional healers and caregivers, but rather to describe the role of caregiving in return for societal status. The expectation is sometimes referred to as the social contract of physicians and provides some background to the SA discourse (Cruess and Creuss 2004).

This anthropological background can help us to highlight some specific details of the current SA discourse. The key idea is not about the fact that physicians need to be accountable. It is also important to note that, while the term 'social accountability' may not have been used, since the 1960s individual schools (particularly those in lower income countries and rural areas) have practiced the principle of SA through training skilled primary health care physicians for community health and underserved areas (Preston et al. 2016). The call for SA is about changing medical education in order to make institutional and systematic efforts to account for community needs. As detailed, the WHO first defined the SA of medical schools in 1995, following from the 1993 WHO discussion paper entitled, 'The Five-Star Doctor: An Asset to Health Care Reform' (Boelen and Heck 1995) and the 1994 WHO-WONCA (World Organisation of Family Doctors) conference held in Canada. The focus of the conference was 'Making Medical Practice and Medical Education More Relevant to People's Needs: The Contribution of the Family Doctor' (WHO 1994). In 2000, the WHO published a working paper entitled 'Towards Unity for Health: Challenges and Opportunities for Partnership in Health Development' (Boelen 2000) that introduced the concept of the Partnership Pentagram. Instead of from the top down, it had to be communities that collaborate with health policymakers, health administrators, health professionals, and academic institutions to identify and address people's health needs.

Results

Interviews with participants in our project were often conceptual, which helps us to outline how the participants define and describe SA; the art activity was more vivid and colorful, which helps us to visualize how the participants associate their thinking and feeling. As one of the participants (a rural physician) described, there is a division between 'a political lens as opposed to a medical education lens' in practice. By politics, the participant refers to institutional policy-making and administration. The medical education lens refers to 'the care for our community and the patients in it,' and the political lens refers to the general institutional directives and policies. According to the NOSM participant, 'most of my colleagues pay zero attention.' We also find that there are different emphases between participants from the medical and health profession and those who study or work in other fields. The former group tends to associate SA with ideas concerning collaboration with communities in responses to their needs; the latter puts the responsibility in a larger 'global mindset' (as another participant put it). They tend to interrelate SA to issues of climate change, racism (especially in the context of 2021 over 'Black Lives Matters' protests and the wrongdoings against Indigenous people), misinformation (especially during pandemic lockdowns), etc. At JCU, a recurring theme was equality and equity between rural, remote and Indigenous communities accessing health and medical care. Interestingly, JCU's analysis finds no usage of the prompts concerning social justice – the theme is inherent within the context of health and understood by the participants in the medical field. As one of the participants in the NOSM group summarizes, the political lens is about 'social justice' and 'equity.'

To the question concerning what one fears the most about SA, practitioners who are not in the medical field

Table 2. Sample interview excerpts.

North American excerpts	Background
Social accountability … **ends up … elephantlike …** the way we describe what happens **when government gets hold of something**. As a communicator … I have a very different understanding of social accountability than my fellow board members … who see things through **a political lens as opposed to a medical education lens** … .	Rural physician and administrator
What we're all about is **providing appropriate care in the appropriate setting for the people we serve**. I think from a social accountability point of view what we have to do is to look for **a more sustainable model**.	Nephrologist and administrator
I go with the World Health Organization's primary health care – **health for all** … . **I wouldn't have called it accountability … . I would have called it social justice or equi-diversity inclusion** …	Nurse and professor of physiology
To me that's part of **being accountable to my community** … is to involve them … and give them **not just a token voice but a genuine voice** … .	Nurse practitioner
[SA] becomes **a tight roping act** for whether the CEO or anybody that's underneath, having **conflicting goals of rules, policies, regulations …** all these things that are **bureaucratic in nature**, and then we have to manage things with limited resources or funding … .	Hospital physician
I guess my one fear would be that **it doesn't change anything**. It's again **just something that the government or whatever check box** or a company or for this one it would be healthcare has to check off they have.	Physician and preceptor
Social accountability for me is **rooted in equity and social justice**. Our root concerns should be creating a healthcare workforce that makes our communities healthier and does so through **an equity lens** … and by that I mean **seeking to … redress economic discrepancies … redress a physician workforce**.	Medical student
We need to **take care of society not just individuals**.	Medical student
[SA is a] **responsibility to greater good**, but individual actions are influential.	Medical student
COVID-19 for some has really revealed the **inequities** for some. I will always be **wary of people who talk about social accountability, talk and talk and talk about it**.	Community member
Everything that is happening in the world right now between the global **climate** strikes, and **Black Lives Matter** … . **racism**, **poverty**, **inequity**, **climate justice** …	Community member
Doing a welfare policy degree and so taking a lot of social work, **my biggest fear is having policy people or other types government people to ask people on the front lines what they think needs to be changed** … .	Community member
What I fear about social accountability is that … there's going to be a bit of a **backlash** … . **The politicians love to make grandiose announcements** … .	Community member
[There] needs to be person-centered care. **Don't judge someone on their sex or ethnicity** – look at me for who I am.	Community member
JCU excerpts	
Interviewer: … you have any **underlying personal values** that align with this idea of social accountability?	Medical student
I think **social justice**. Because the medical field is really a field where you can create a lot of change when it comes to marginalised communities and then people who are in war-torn countries. It's the role of the medical professionals to come and **step in and help** the community.	
I guess society always puts the doctors . . . they see doctors on this pedestal. The sort of doctor I want to be is someone who's grounded and not . . . you know, because I have respect for them, **I see them (patients) equal to myself; I don't see them any higher – any higher or lower than me.**	Medical student
I'd like to think that people could be treated **fairly and equally** and have access to the same opportunities in healthcare and education, all those things. And obviously it's different whether you live in rural and remote, or metropolitan communities. But ultimately, all people should have equal opportunities for everything.	Faculty (medical background)

tend to describe the challenge of a kind of monolithic or hierarchical system that puts medical practitioners at the top. The power structure contributes to an accountability gap and a lack of compassion that can only be addressed through a concerted effort in building SA institutions. Those in the medical field, in contrast, talk about institutional and bureaucratic concerns overtaking the care for the community.

Although the word 'compassion' comes up rarely in our transcripts, the idea materializes in the recurring motif of 'care' among many participants regarding SA with the medical education lens; also, community, collaboration, and care are three main themes that often appear together in the arts of the participants. Indeed, it was through sharing the artworks in our biweekly meetings when we recognized the hidden role of compassion in the discussion. We may be tempted to generalize that people who are not in healthcare are confusing social responsibility in global politics with SA in medical practice. However, although the two groups have different lenses and perspectives, they are not in conflict. As another participant in the medical profession synthesizes, SA is about 'taking care of the community, protecting the most vulnerable and underserved.' The two lenses form a parallax that allows us to perceive a deeper view of care in the medical professions' active role to help achieve equality and equity.

When answering our question about what they fear about the idea of SA, our participants suggest that SA can become 'bureaucracy,' 'empty jargon' and administrative 'slogan'; to engage SA, one needs to care in order to drive the 'words into action' and to foster 'meaningful relationships' in response to community needs. In a way, community members are in tune with some participants in the health profession who reject 'grandiose announcements' and desire responsible community-engaged actions.

Here are some highlights from our transcripts (Table 2).

Discussion

The recurring theme of social justice leads us to trace the evolution of the concept of compassion and its relation to SA. World Religion scholar Karen Armstrong (1994) regards the full realization of the importance of compassion as a major development of what Karl Jaspers calls 'Axial Age' (800-200 BCE). In this period, she explains, the rise of merchants along with new wealth led to dramatic changes in ideologies that 'have continued to be crucial and formative' (Armstrong, p. 27; Jaspers, p. 8–29). As inequality and exploitation became more obvious with the merchant class, new religion and politics began to address issues of social and economic injustice. One quintessential example is

Judaism's shift from sacrificial rite (as seen in the Torah) to social justice and compassion (as seen in the Books of the Prophets). In the first chapter of Isaiah, the prophet tells the Israelites, 'Why do I need your numerous sacrifices? says Hashem. I am sated with elevation-offerings of rams and the fat of fatlings…' (Isaiah 1: 11, TANACH 1996, The Stone Edition). Instead, the new instructions emphasized justice and compassion: 'Learn to do good, seek justice, vindicate the victim, render justice to the orphan, take up the grievance of the widow' (Isaiah 1:17). Armstrong (1993) comments, 'The prophets had discovered for themselves the overriding duty of compassion, which would become the hallmark of all the major religions formed in the Axial Age' (Armstrong, p. 44). In other words, Judaism and its subsequent Abrahamic religions have since the Axials age already motivated the struggle for social justice with compassion.

Contemporary medical science also tracks the formative function of compassion. In *Compassion and Healing in Medicine and Society*, psychiatrist Gregory Friccione describes compassion as a necessary 'attachment' in the evolution of humanity as a mammalian animal. He hypothesizes with a psychiatric framework that humans become conscious organisms as 'living organisms develop awareness of objects in their surroundings as an evolutionary necessity' (Friccione 2011, p. 274). He sees compassion as a natural development for mammalian survival and success. By natural selection, the human species evolves into a social-cultural animal that gains survival advantages from attachment and working together: 'the memes that service our attachment behaviours are not really transcending our genes but enhancing those that nourish our socially inclusive and loving natures, as opposed to those that limit our compassion' (p. 343). Friccione, therefore, includes the role of cultural mechanics in cultivating human compassion: 'the true hope of the major spiritual traditions is that refined and enhanced attachment memes based on the mammalian triad become more inclusive and universal among humans' (p. 342). This view connects us back to Armstrong's history of God. The beginning chapter of Isaiah, however, unacknowledged or forgotten, may be the ideological foundation of Western medicine's ethical tie to compassion. What is more is that the '*duty* of compassion' expressed in Isaiah goes hand in hand with the demand for justice – or in our contemporary terminology, 'social accountability.'

As seen in our transcripts, the participants often have convergent ideas about the SA of medical education and issues of equity and equality involving the fight against racism, gender discrimination, environmental destruction, and other social justice causes. This social-political consciousness reflects the co-evolving relation between SA and the duty of compassion.

JCU's transcripts make interesting comparisons. As the question draws attention to 'personal values,' the critique of the SA's institutional practice does not come out as strongly as the North American partners do. Nevertheless, the theme of health care equity is clear at JCU among medical students and faculty members. Compassion is expressed in light of the desire to take action for equity, particularly in one of the medical students who sees patients as ones not higher or lower, which really fits the meaning of '*com*' in compassion.

Recommendations

It is important that we do not teach SA by itself as a 'policy' or a 'mandate.' Instead, in order to be socially accountable, we need to humanize our medical schools to teach compassion in many aspects by (1) including compassion training in the curriculum and (2) modeling compassion in the institution.

Including compassion training

Teachings of compassion can be intricately incorporated into the medical curriculum. For instance, as Connie Hu, a medical student has experienced at the University of New Mexico, early on in medical education, medical students are often asked to reflect on experiences that help them to understand the situation and other perspectives in hopes of growing their empathetic awareness. Mindfulness and wellness training in medical schools have become more important to prevent burnout, which may lead to depression, suicide, and suboptimal patient health outcomes (Shanafelt et al. 2015). The University of Louisville School of Medicine conducted a study on the implementation of a compassion training elective. The results show that not only does compassion training strengthen interpersonal interactions, but it also helps students 'address major stressors associated with personal, academic, and clinical responsibilities' (Weingartner et al. 2019). At the individual level, compassion training needs to include the perseverance of the mental health of the students because, without being able to care for themselves, they may be unable to show compassion towards others.

Modeling compassion

The educational institution may also show compassion for students academically and professionally, such as allowing flexible hours, promoting self-compassion, and giving a space for rehabilitation while reinforcing regulations. In designing curriculum, compassion training can be developed side-by-side with community placement and community-engaged programs: i.e. teaching learners how to listen compassionately to community members and self-compassionately to themselves as a socio-political act.

Students become acculturated to their profession within the process of medical training. Therefore, having strong role modeling is critical to their experiences and the very nature of their training needs to honor and support compassionate behavior. To achieve this goal, it may be helpful to consider the use of a relationship-based and engaged partnership model of teaching (hooks 1994). As compassion has been a defining characteristic of a good physician, many medical schools have already incorporated admission criteria and training programs to select and develop compassionate physicians. In light of our findings, we would argue that this emphasis on cultivating compassion in medical students might have already been an act of SA. However, we may develop further in the way medical schools operate: medical schools as educational institutions may operate themselves with compassion as a driving force in engaging partnership with students and communities.

Social accountability without compassion is not SA; compassion humanizes institutional policy by engaging sympathy and care.

Conclusions and further study

Based on our biological–historical–anthropological synthesis of the meaning of compassion and SA, in comparison to the analysis of our interview transcripts on care and SA, we argue that SA without compassion is not SA. The two concepts are expressions of the same ethical necessity: while the SA mandate expresses the necessity from an institutional perspective, compassion humanizes institutional policy by engaging sympathy and care.

These two points imply structural and philosophical changes beyond accreditation standards, simple amendments of policies and procedure manuals. We cannot regulate or mandate compassionate behavior, but we can encourage and nurture it. Modeling and training compassion means that we need to keep a central place for compassion in our approach to all aspects of administration and education. The idea of integrating compassion in institutional culture, in fact, deserves further study, innovations, and trials to discover best practices.

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Glossary

Compassion: Compassion's Latin root 'com' means 'with' and 'Pati' (passon) means 'to suffer.' Compassion literally means 'suffering together with another.' The term denotes the feeling or emotion, when a person is moved by the suffering or distress of another, and by the desire to relieve it. Oxford English Dictionary.

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