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Compassion is the key to Patient Compliance and 'paradigm shift acceptance' for Chiropractic patients

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Abstract: Purpose: To provide a qualitative report using accepted techniques from the Humanities of the place of compassion first in medical and health care and second in chiropractic care including my own practice.

Methods: A Narrative Analysis was undertaken of the literature expanding outwards from accepted definitions of 'compassion' to seek reported stories and studies whose actions are considered compassionate and were shown to be related to clinical outcomes. An Interpretative Phenomenological Analysis was made of conversations which reflected attitudes to expressed compassion. I was unable to develop a Thematic Analysis as the literature is sparse at this time, however Conversational Analysis together with Self-Reflection on my own clinical encounters allowed me to draw conclusions.

Conclusions: I report the beginning of a shift in the general approach to doctor / patient communication. Here I report a positive change in the healthcare system and in the health of the individual where patient interactions are guided by compassionate care. I argue for improvements in the definition and meaning of the terms: sympathy, empathy, and compassion; these need to be well defined to eliminate current confusion in the literature. It is recommended that compassionate care must be integrated into the healthcare education system and institutions if this profound change in healing, not just curing, is to occur. Chiropractic care and the Chiropractic paradigm in particular might benefit greatly by the investment of time and energy in compassionate care training. Further studies concerning the ability to develop compassion as well as select individuals with compassion are needed.

Indexing Terms: chiropractic; paradigm shift; compassion; patient-focussed care.

Introduction

In this post COVID era history will decide how well, or not, our society performed in the realm of public health care. But now we must evaluate the damage done to our already fragile healthcare system and its integrity and try to understand the curative changes that must be implemented. We will observe here through many studies that a connection exists between treatment outcomes, patient compliance, and patients' trust, and how they feel understood

> *... The presentation of the Chiropractic paradigm might be better accepted by a wider group of probable patients if it were presented with a more compassionate approach towards the patient'*

through inclusion of compassion in healthcare.An increasing number of investigations have found positive relationships between clinical-patient communication, treatment compliance, and a variety of health outcomes, including better emotional well-being, lower stress and burnout symptoms, lower blood pressure, and a better quality of life (for both doctors and patients). As well, it is found that poor communication between health care professionals and their patients is a key issue in the increasing number of complaints against health care professionals worldwide.

This paper will examine and discuss the connection and differences between healthcare provider compassion and healthcare outcomes as well as clarify the differences and misconceptions between sympathy, empathy, and compassion.

Narrative

It is both interesting and revealing that Dorland's Medical Dictionary does not even include a definition of the word, 'compassion'. This while so many studies discuss and lament that lack of compassion on the part of the healthcare provider leads to poor medical treatment and disastrous clinical outcomes. (1) This is seen as exemplifying the difference between compassionate and non-compassionate responses to patients seeking help. Many chronic pain studies argue in support of approaching patients with persistent pain with a trusting attitude, rather than distrust or skepticism, prejudging patients as fabricators in search of narcotics. (2) Edelman's 2022 Health-Trust Omens finds '*that 71% of people feel a decrease in their confidence in the healthcare system. Peoples' confidence in their ability to find answers about healthcare questions and make informed health decisions has declined steeply over the past five years.*' (3) There is a need to repair these public images.

There is only a small movement of people creating studies concerning this topic, and those studies many times seem to be off the mark. '*Sympathy, empathy, and compassion are used interchangeably and frequently conflated in health care literature, while the patients demonstrate that they clearly distinguish and experience each uniquely. Understanding patients' perspectives is of the utmost importance and should guide practice, policy reform, and future research*'. (4) One finds, upon undertaking the search for research concerning compassion, that the great majority of published articles and studies appear to be concerned more with self-compassion on the part of the physician as a means to eliminate physician burn out, instead of investigating compassion towards for the patient. This ironically frames the entire problem quite well. It appears that this attitude is a reflection of the entire medical education/practice paradigm.

Where does one begin to look to find where the problem starts? As discussed in one study medical students stated '*Before medical school, I had never known the meaning of the word "gunner". The term refers to a student who will sabotage his peers in effort to be number one. Though gunners have been ubiquitous and filling medical school classes for years, it is interesting to note that there has never been coined a term for the opposite of a gunner*.' At some schools studies find the entire academic culture toxic. '*Students are expected to master material on their own; seeking help is seen as a sign of weakness*.' Nearly half of all medical students report having been publicly embarrassed by faculty, staff, or peers. Many talented young people have taken note of these negatives and decided that medicine may not be the right field for them. '*The number of med school applicants has essentially been flat or in decline for the past decade*'. From the very beginning the medical education, the culture, is actually the direct antithesis of empathy/compassion and this is palpable to prospective students and patients alike. (5, 6)

Another factor, although a necessary one, that seems to be another brick in the wall between doctor and patient is the necessary emphasis on science and technology in medicine. Although crucial to the practice of medicine and crucial to the well-being of the patient, it has created a generation of physicians who treat the test, not the patient. It has created physicians who believe technical skill trumps bedside manner and who find it difficult to relate to their patients about their

suffering. Studies have cited as well the time constraints and economic pressures placed on the doctors as adding to the challenge of giving meaningful time to patients. Patients want to talk to their physician about their concerns, but surveys indicate that this is not being accomplished. (7)

Difficulty arises also through misunderstanding exactly what the patient understands and what the doctor believes the patient understands. There is a conflation of the terms, sympathy, empathy, compassion. This due to misunderstanding their unique messages, rendering many research outcomes questionable.

This misunderstanding creates a difficulty in parsing out the true results of studies. There is a clouding of the definition between what the study producers understand the questions to be, and what the study participants understand. Let us here attempt a resolution of the confusion. According to the *Dali Llama*, quite the expert in the field of 'empathy', 'sympathy', and 'compassion'. '*These are three words that many use interchangeably, but they are not synonymous with one another*' *They are however, close cousins, but not synonymous with one another*.' (8)

The prefix '*sym*' is Greek, meaning '*with or together*'. The suffix '*pathy*' is derived from the Greek *Pathos*, meaning feeling. Sympathy means you are with the feeling, but not wholly invested. One can understand what the person is feeling.

'Empathy' in Greek means '*in the feeling*'. This means that you can feel what a person is feeling. Compassion however, is a completely different word. Not *Pathos* (feeling) but '*Passion*'. The literal meaning of in Greek of passion is suffering. 'The only virtue of passion is compassion, which translates to "*suffering with*"'. When we are compassionate to a cause, we suffer with that cause. This is the next level, having the drive to relieve the suffering of another.

Compassion, sympathy, empathy

To further understand, clarify and present our terms in a workable fashion one must look profoundly at the differences between compassion, sympathy, and empathy. Studies are becoming congruent on general understanding of these terms. Sympathy means you are able to understand what the person is feeling. With sympathy, one can understand or imagine why someone is either going through a hard time or why someone might be feeling happy or sad. For example, although you might not feel the same grief, you can understand why someone might be grieving if their close friend passes away. Empathy might be considered the next step in interpersonal relationships. It is viscerally feeling what another feels.

We can feel what another person is going through thanks to what researchers have called '*mirror neurons*'. (9) Mirror Neuron System (MNS) are related to specific neurons which are involved with high-order social cognitions such as emotion and empathy (10). These MNS appear to have developed as an evolutionary need to learn from others' experiences. (11) Empathy may arise automatically when one witnesses someone in pain. For example, upon observing someone hit their finger with a hammer. One you might feel pain in one's own finger as well. That feeling means that well developed mirror neurons have been stimulated. The brain areas for pain in that same cortical region are stimulated and the same pain or other visceral reaction is elicited. There might be a diminished response as one might only be able to imagine how it must feel, or perhaps one might pick up cues from the other's facial expression and imagine what they might be feeling. This is the key difference between empathy and sympathy; the difference between understanding a feeling versus actually experiencing another's feelings.

Actually, feeling a pain, or the visceral response of the hair on the back of your neck stands up, or you feel nauseous. These visceral connections are a key. Typically, people can sympathise much easier than they can empathise.

Compassion takes empathy and sympathy a step further. When you are compassionate, you feel the pain, suffering of another (i.e., empathy) and you recognise that the person is in pain (i.e., sympathy), and then you do your best to alleviate the person's suffering from that situation. '*When you're compassionate, one is not running away from suffering, one is not feeling overwhelmed by*

suffering, and one is not pretending the suffering doesn't exist. When one practices compassion, it allows staying present with suffering. Showing compassion can help gain perspective or a new point of view because it gives the view from someone else's shoes and creates the time and thought into alleviating someone's suffering'. (12)

These definitions have resonated with other authors and have been correlated in brain studies. Unlike empathy, compassion increases activity in the areas of the brain involved in dopaminergic reward and oxytocin-related processes, and enhances positive emotions in response to adverse situations. (13) This is the critical property of compassion that differentiates it from empathy.

Because compassion generates positive emotions, it counteracts negative effects of empathy elicited by experiencing others' suffering. The dopamine depletion that occurs from activation of the pain networks that occur with empathy, offers no resolution. However, the neural networks activated when people feel compassion towards others activate brain areas linked to reward processing. These brain areas are full of receptors for oxytocin and vasopressin, the neuropeptides that are crucial in attachment and bonding. Compassion does not fatigue, it is neurologically rejuvenating. (14)

Burnout

This lays at the root of all the studies investigating physician burn out due to compassion, they have mislabeled empathy and that is the problem. It is noted that many healthcare workers when feeling strong prolonged empathy chose to avoid investing themselves in the patients as an attempt to protect themselves from the feeling that they are having. This leads to detachment, and subconsciously repressing clinical facts as a defense mechanism against burn out. (15) When locked into empathic distress, we have a blunted capacity to experience pleasure along with decreased motivation for natural rewards. Chronic depletion of dopamine from repeated episodes of empathic distress is what leads to burnout, characterised in health care professionals as emotional exhaustion, withdrawal, depersonalisation, and a decreased sense of personal accomplishment due to work-related stress. An illuminating statement was given, '*Instead of withdrawing and rushing through the procedure in self-defense, compassion enables me to slow down and be present with my patient without experiencing distress*.' (16)

As one begins to read more studies concerning compassion and healthcare, the current manner utilised in evaluation in scientific studies presents a stumbling block. Performing a quantitative analysis of how much compassion one might posses may prove to be a fool's errand. How does one measure compassion on a scale from 1 to 10? Is *1* is a sociopath and *10* The Buddha? This leaves one frustrated, but instead of quantifying how many pixies can dance on the head of a pin, a broader analysis is suggested.

The discussion of compassion has brought to focus on conceptualisations and measures of compassion that have been put forward. One study develops three new measures of compassion competencies derived from an evolutionary, motivational approach. The scales assess

1. the compassion we experience for others
2. the compassion we experience from others, and
3. self-compassion based on a standard definition of compassion as a '*sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it*'.

It was proposed that some criteria would be attitudes in relationship to other compassion scales, self-criticism, depression, anxiety, stress and well-being. (17) It has as well been promoted that compassion might be measured clinically through, '*Effective communication associated with improved patient and physician satisfaction which can be evaluated in outcomes as: better patient compliance, improved health outcomes, better-informed medical decisions, reduced malpractice suits*'. (18)

As stated some national certifying examinations also are being designed to incorporate compassion skills. Although written material is useful in increasing awareness of the importance of good physician-patient communication, behavioural evaluation and hence change is more likely to

occur in a workshop environment. (19) The *American Academy of Orthopaedic Surgeons* is taking leadership in designing and implementing such an approach for its membership. (20)

Many medical schools are beginning to incorporate courses in mindfulness and compassion. This is based in an assumption that compassion can be taught; and that if it can be taught, can it be taught to adults who have already developed certain habits or attitudes. (21, 22)

Student perspective

Until recently scientists knew very little about whether compassion could be cultivated or taught. It has been found that increasing severity of past adversity predicts increased empathy, which in turn is linked to a stable tendency to feel compassion for others in need. (23) As a suggestion for best utilisation of resources and time, perhaps the structure of the medical school recruitment process, which currently favours the '*cutthroats*' and '*gunners*' can be revisited. We know that the personality types of gunners and cut throats have poorly developed mirror neurons, as their sense of empathy and compassion are blunted. Why not begin the process then with filtering for individuals who already are compassionate? This has already begun on a small scale. There are some institutions who are employing new applications which begin to include questions to judge the personality of the candidate. (24)

As some institutions begin to explore this new model, new studies suggest that students experience higher barriers to compassion as clinical training progresses. This is in contrast to previous studies contrasting physicians with medical students, where greater experience was associated with lower perceived barriers to compassion. (25) Perhaps this study confounded clinical training advancement with actual years of experience in dealing with patient suffering.

To complete the picture Sinclair and others have concluded, '*that a realist review determined that compassion training may engender compassionate healthcare practice only if it becomes a key component of the infrastructure and vision of healthcare organisations, engages institutional participation, improves leadership at all levels, adopts a multimodal approach, and uses valid measures to assess outcomes*'. (26, 27) Sinclair in his study is signalling here that the system needs to change. That the entire system, "at all levels" needs to recognise the need for humanistic care. Obviously, if the institutional mindset that encourages the problem remains; how can change occur?

Chiropractic practice

The effect of the affect of paying closer attention to compassion in Chiropractic practice can be greatly beneficial. It is found that Chiropractic, already has a high degree of patient confidence and satisfaction. (28, 29, 30, 31) Apparently Chiropractic does not suffer as much from these issues as does allopathy. Is this perhaps Chiropractic attracts a different pool of candidates? This could be an interesting study. However, considering Chiropractic, there is always room for improvement as chiropractic treats about only 10% of the population of the US. (32)

Chiropractic must be compelled to consider the patient/doctor interactions as Chiropractic requires much more from patients than does allopathy. It requires that the patient consider a new paradigm for healthcare. The underlying ironic conundrum being that most patients do not even know they are functioning under any healthcare paradigm at all. They are just following what they have been told by parents, teachers, neighbours, friends, the television, and the media; daily figures of authority. '*Most people walk through the world in a trance of disempowerment. Our work is to transform that into a work of empowerment*', Milton Erickson (father of *Ericsonian hypnotherapy*).

It appears to be a herculean task, but an extremely worthwhile one, carrying the message of Chiropractic's effect on health. One must remember that the patient will, upon exiting the chiropractic office each time, be bombarded by the realm of the hungry ghosts. (33) Those who will drag one down to their tone level. The power of societal sabotage is ever present. The individual who suggests doing the most against-the-norm thing to the social circle will receive responses like, '*oh, ha-ha, good luck*' or '*yeah, okay, we'll see how this goes*'. Or '*I know someone who died from that*'. (34) One must remember that the individuals who attempt to try something different represents to the

group a challenge to '*self*'. This most people do not want to contemplate, let alone undertake. Complacency is very comfortable, change is difficult. People would rather continue in their negative cycle, however poor that outcome might be, than do the internal work it takes to rise above.

The chiropractic paradigm

The presentation of the Chiropractic paradigm might be better accepted by a wider group of probable patients if it were presented with a more compassionate approach towards the patient. It is imperative to remember that the patient comes into the chiropractic office with their baggage held tightly. In many cases with such a profound link to their '*diagnosis*' that it almost defines '*who they are*'.

There is a principle know as *stable datum*. It explains that the one idea that the person holds becomes their focal point. It helps bring immediate order to their confusion controlling their entropy; even if that datum is negative to long range survival. Patients come to the office with concern, worry about the '*symptoms*', the '*body signals*' they are feeling. Their '*diagnosis*' supplies them with an anchor, a name for their problem. Psychologically this provide a very strong bond. People fear the unknown. (35) '*The oldest and strongest emotion of mankind is fear, and the oldest and strongest kind of fear is fear of the unknown*'. (36)

Similarly, Carleton and others have argued that fear of the unknown may '*be the most basic component of pathological anxiety*' and '*a fundamental component of all anxiety disorders*'. (37, 38, 39, 40, 41) Dislodging the stable datum, questioning the rationale of their diagnosis, disturbs the patient's house of cards and leaves them without control. Therefore, before the veritable rug is pulled out from under the patient there must be established for them a meaningful, palatable alternative. (42)

Compassionate care is the way to establish that alternative. As Dr Haidt explains, the emotions must be appeased before the intellect can engage. (43). We need the patient to make that emotional connection as the job of healing is a difficult one. The roles of the patient and of the health care practitioner in curing versus healing are not just different, they are diametrically opposed. The goal of the patient in the curing mode is survival. This includes physical survival, survival of all that represents self to the patient. This includes view of one's physical appearance, lifestyle, and relationships. In other words, '*the patient's goal is to avoid change*'. '*Healing, on the other hand, comes from the acceptance of change*'. This acceptance of change allows the patient to grow to a new sense of self, as a person with a new experience of integrity and wholeness that is different than the old status quo. '*In curing, the patient depends on the expertise of the practitioner to control disease; in healing, the patient begins to realise that it is his or her own resources that will finally lead to growth and that he or she is responsible for managing those resources*'. (44) The patient/physician dynamic as one can see is a complicated one. One that needs to be properly analysed and fine-tuned.

The patient/physician dynamic

Analysing and fine tuning will have enormous impact since studies performed are already indicating that many patients are disenchanted with the current medical system/model in many countries. They are ready for change. This for many reasons, one being the apparent lack of communication/caring. (45) This places Chiropractic in position for huge growth potential. However, like in all endeavours with the general population, one must give them what they want, not what we want, not what we think they want, and not even what we may know they need.

Haidt describes the human psyche as an elephant and its rider. (46) The elephant represents the motivation through emotions, and desires; while the rider represents the motivation through intelligence. As hard as the rider pulls and pulls, the huge elephant will continue on its path driven by emotions. Attempting to use logic, reason, facts with the patient may not work. The rider may comprehend the needs for that patient, but the elephant's desires and wants will win out. This is why the use of compassion is so important when dealing with the patient in need, or anyone for that matter. Unless the patients' emotional connection to their condition is addressed and they feel

'*understood*', they feel that you understand their problem, you understand their wants, it will be difficult to have them commit to their needs. (47)

Chiropractic must embrace and employ patient-centred communication because it promotes positive patient outcomes and patient attitudes. Jawad, in his study '*examines the linguistic markers of two key dimensions of patient-centered communication* (i.e., provider compassionate care and shared decision-making) *and how they impact the patient's perceived quality of and affective responses to the provider's treatment recommendations*'. Results showed that providers' use of affiliation words positively predicted patients' perceptions of their providers' compassionate care. Conversely, Providers' use of insight words negatively predicted patients' perceptions of provider shared decision-making. The Patients' feeling a compassionate care and shared decision-making created an increase in patients' positive opinion of the quality of treatment recommendations. '*These perceptions also reduced their negative affect toward the recommendations*'. (48) Most notably, patients liked their physician more when physicians chose fewer negative emotionally charged words, and tended to not follow recommendations when physicians used more singular first-person pronouns. (49)

It appears that seemingly unscientific terms that a few years ago would make physicians and Chiropractors bristle: *mindfulness*, *spirituality*, and compassion, are being evaluated scientifically as keys to developing compassionate patient care. Compassionate care that will apparently improve patient compliance and open patients to the chiropractic health paradigm. (50, 51) The value that is now demonstrated leads to the question; *how does one develop compassion?* As well as, can one develop compassion as an adult? Many studies indicate that there might be a period of neural plasticity in which mirror neurons are stimulated when empathy/compassion has its' roots. There are conflicting studies demonstrating both sides of this argument. There are studies that question the entire idea of empathy training. (52) Whether nature or nurture, what the studies all agree on is the value of compassion in patient care.

Mindfulness meditation

One of the mind-body interventions available and being employed by medical schools and medical continuing education is mindfulness meditation. Mindful Mediation has been demonstrated to increase empathy in healthcare providers. (53) '*Mindfulness can be described as non-judgmental attention to experiences of the present moment, including emotions, cognitions, and bodily sensations as well as external stimuli. It is both a practice and a way of being in the world, in which the individuals maintain attitudes such as openness, curiosity, patience, and acceptance, while focusing their attention on a situation as it unfolds. Thus, mindfulness is congruent with the goal in practice to cure disease when possible and meet suffering in a compassionate manner. In this way, mindfulness can be seen as a set of skills that facilitates the healing aspects of the clinician-patient encounter.*' (54) Mindful meditation, through a wakeful hypo-metabolic state of parasympathetic dominance favours a compassionate openness. This opposed to the tension and protective state of hyper sympathetic stimulation. (55)

Mindful meditation does appear to be effective in facilitating the ground work for the development of empathy/compassion. Multiple trials show that a 3-day intensive mindfulness meditation training intervention reduced right amygdala-sgACC rsFC which is linked to stress and fight or flight character changes. Taren demonstrates that mindfulness meditation training promotes functional neuroplastic changes. (56)

There is as well proof that mindful meditation increases circulating melatonin (57) and serum cortisol levels are significantly reduced. (58) There is proof of increase in oxytocin through a hypothalamic-pituitary-adrenal (HPA) axis-oxytocin model. This effects complex human states and behaviours, such as well-being, social bonding, and emotional behaviour. (59) Another study indicates that the oxytocin meditation relationship, in the long-term, produces the lowering of blood pressure and of cortisol levels as well as the sedative effects by increasing oxytocin. This has been found to be related to an increased activity of central alpha 2-adrenoceptors. Positive social

interactions have been related to these health-promoting effects. Oxytocin released in response to social stimuli stimulate neuroendocrine substrates which underlies the benefits of positive social experiences. (60)

Compassion meditation

Compassion Meditation was found to increased compassion, as measured in one study by voluntary charitable donations, and changes in feelings and attributions of the individual. (61) Mascaro found that kindness-based meditation appears to enhance the neural systems related to faster and more basic perceptual and motor simulation processes. It facilitated the ability to simulate another's body state with slower but higher-level perspective-taking. Modulatory processes such as emotion regulation and self/other discrimination were increased, in short this represents compassion. (62)

Tai Chi Chuan

Tai Chi Chuan (TCC) has been employed as well in compassion studies. It is regarded as a typical mind-body practice combining aerobic exercise and meditation. Studies utilised MRI and demonstrated changes in brain anatomy and function, mainly in the prefrontal cortex, following TCC practice. The effects of TCC on emotion/mental health is through a prefrontal cortex hypothesis that proposed '*an immune system of the mind*'. Indicating the role of the prefrontal cortex as a flexible hub in regulating an individual's mental health. There was observed after TCC a greater functional connectivity between the *left anterior insula* and the *dorsomedial prefrontal cortex* suggesting a relationship between the functional brain organisation and the cognitive control of empathy. (63, 64, 65, 66, 67)

Heyes, an outlier, however, contrarily states in his study that '*Empathy is not in our genes.*' He reports that, '*In academic and public life empathy is seen as a fundamental force of morality, a psychological phenomenon, rooted in biology, with profound effects in law, policy, and international relations. But the roots of empathy are not as firm as we like to think. The matching mechanism that distinguishes empathy from compassion, envy, schadenfreude, and sadism is a product of learning, mirror neuron activation and training*'. Hayes presents a dual system model that distinguishes Empathy # 1, an automatic process that catches the feelings of others, from Empathy # 2, controlled processes that interpret those feelings. Research with animals, infants, adults and robots suggests that the mechanism of Empathy #1, emotional contagion, is constructed in the course of development through social interaction. Learned Matching implies that empathy is both agile and fragile. It can be enhanced and redirected by novel experience, and broken by social change". (68)

The Cleveland Clinic

The discussion of compassion, if it is innate or learned will continue, but what is not debated is its importance in health care delivery. So, now is the time to begin our best effort to employ it. The need to develop and fine tune the ability to be compassionate is essential.

Consider that the epistemologies in the curing and healing roles are very different. In curing, scientific knowledge is key and expected in evidence-based practice. In healing however, this is not helpful. The crux of healing is in the interpersonal relationship, one person to another. The role of the healthcare provider in healing has to depend on his/her particular personality and qualities as a person, and the interaction with the particular characteristics of the patient. It is an art, rather than science, which best prepares the physician to be the facilitator in the healing relationship with the patient. (69)

The *Cleveland Clinic* has begun to actively address this issue. Communicate with H.E.A.R.T® (Hear, Empathize, Apologize, Respond, Thanks) is *Cleveland Clinic's* service excellence model newly integrated into their culture. This novel program '*empowers employees to provide an exceptional patient and employee experience at every point of interaction by helping them to understand that their role in creating positive patient experiences is greater than the tasks associated with their job*'.

To communicate with H.E.A.R.T.® '*establishes expected service behaviours; provides a service recovery framework; and demonstrates how personal accountability sustains a culture of empathy*'. The only short coming in this program is again the confusion between empathy and compassion. Here *Cleveland Clinic* is promoting empathy, however, according to most studies, empathy will be increasing physician burn out while ironically failing to attain the changes the patients so desperately desire. Again, we see the importance of definition of terms. (70)

Conclusion

There is beginning a shift in the general approach to doctor/patient communication. Here we report a positive change in the healthcare system and in the health of the individual where patient interactions are guided by compassionate care. We argue for improvements in the definition and meaning of the terms: sympathy, empathy, and compassion; these need to be well defined to eliminate current confusion in the literature.

It is recommended that compassionate care must be integrated into the healthcare education system and institutions if this profound change in healing, not just curing, is to occur. Chiropractic care and the Chiropractic paradigm in particular might benefit greatly by the investment of time and energy in compassionate care training. Further studies concerning the ability to develop compassion as well as select individuals with compassion are needed.

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