La sfida del paradigma della compassione nella medicina, nella sanità e nelle professioni di aiuto del 21° secolo nell'era digitale

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Sommario

Il contributo inizia delineando il costrutto della compassione e la sua evoluzione nella letteratura scientifica. Vengono descritti i principali strumenti per rilevare il costrutto della compassione ed esempi di training per incrementarlo. Viene anche offerto uno sguardo su compassione e medicina nel corso degli anni. Inoltre, viene presentata una panoramica sui training relativi a compassione in medicina e salute. Infine, il contributo delinea il valore del paradigma della compassione nelle professioni mediche, sanitarie e di aiuto nel 21° secolo e la sua necessaria integrazione nell'era digitale.

Parole chiave

Compassione, Paradigma della compassione, Medicina, Assistenza sanitaria, Professioni d'aiuto, Era digitale.

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The Challenge of the Paradigm of Compassion in 21st Century Medicine, Healthcare and the Helping Professions in the Digital Era

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Abstract

The contribution starts by delineating the construct of compassion and its evolution in scientific literature. The principal instruments used to detect the construct of compassion and examples of training to improve it are described. A presentation of compassion and medicine over the years is also offered. Furthermore, an overview on compassion training in medicine and health is presented. Finally, the contribution delineates the value of the paradigm of compassion in 21st century medicine, healthcare and the helping professions and its necessary integration in the digital age.

Keywords

Compassion, Paradigm of compassion, Medicine, Healthcare, Helping professions, Digital age.

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The construct of compassion

The term «compassion» comes from the Latin *cum patior* — to suffer with — which can be traced back to the Greek συμπάθεια. It traditionally refers to a feeling on the basis of which an individual emotionally perceives the suffering of others wanting to relieve it.

A wide consensus seems to emerge in literature that compassion includes not only perceiving the suffering of others but also being motivated to help them (Goetz et al., 2010; Lazarus, 1991; Strauss et al., 2016). Various definitions have followed over time. Lazarus (1991) defines compassion as being moved by the suffering of other people and having the desire to help them. A later definition (Neff, 2003) considers compassion as «being touched by the suffering of others, opening one's awareness to others' pain and not avoiding or disconnecting from it, so that feelings of kindness towards others and the desire to alleviate their suffering emerge. It also involves offering non-judgmental understanding to those who fail or do wrong» (p. 86-87). Subsequently, Kanov et al. (2004) started a study on multidimensional approaches to the construct of compassion. The authors identify three aspects: noticing, feeling, and responding. Subsequently, Gilbert (2009) defines compassion as a deep awareness of another person's suffering, combined with the desire to alleviate it, and identifies aspects such as sensitivity, sympathy, empathy, motivation/caring, distress tolerance and non-judgment. The following year Goetz et al. (2010) refer to compassion as «the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help» (p. 351) and Pommier (2010) underlines that compassion includes kindness (being sympathetic towards others who are suffering instead of being indifferent or critical towards them), mindfulness (noticing another individual's suffering and being open to it without feelings of distress that separate from that individual), and common humanity (understanding that all humans suffer). In 2011 Feldman and Kuyken affirm that compassion is «an orientation of mind that recognizes pain and the universality of pain in human experience and the capacity to meet that pain with kindness, empathy, equanimity and patience» (p. 145). In 2013, Martins et al. defined compassion as being moved by the suffering of others and having the desire to lessen it. Monitoring and managing levels of compassion through social networks and relationships can be crucial, on the one hand, to preserve health benefits and, on the other hand, to prevent the health risks of social networks and relationships (Martins et al., 2013).

Strauss et al. (2016), reviewing literature on compassion, highlighted the multidimensional nature of the construct. Based on their conclusions, the construct of compassion comprises five dimensions: (1) recognizing suffering; (2) understanding the universality of suffering in human experience; (3) understanding the feelings of suffering people by emotionally connecting with their anguish;

(4) tolerating any feelings of aroused discomfort (for example, fear, disgust, distress and anger) in such a way as to remain open to people in their suffering; (5) acting or being motivated to act to alleviate suffering. Starting from Strauss et al. (2016), the construct of compassion was defined by Gu et al. (2017) as the emotional perception and recognition of suffering of other individuals, desiring to alleviate it, understanding that suffering is universal, feeling emotionally connected with others' suffering, tolerating uncomfortable feelings (e.g., fear and distress) and thus remaining open to accept other people's suffering. In line with the evolution of the construct of compassion, different instruments have been developed to measure it.

Measuring compassion

In chronological order, the following measurement scales can be found in scientific literature.

Compassionate Love Scale (CLS; Sprecher & Fehr, 2005). This is considered to be the first instrument developed to measure compassion. In reality, this instrument evaluates compassionate love in intimate relationships and towards people in general. Sprecher and Fehr (2005) define compassionate love as an attitude towards others, both towards loved ones and towards strangers belonging to the whole of humanity, containing feelings, cognitions and behaviours that are focused on caring, interest, tenderness and an orientation towards the support, help and understanding of others. They also emphasize that their definition is in line with that of Lazarus (1991), who defines compassion as «being moved by another's suffering and wanting to help» (Lazarus, 1991, p. 289). Sprecher and Fehr (2005) choose to use the term «compassionate love» instead of «compassion» to include emotional overtones in the construct, although they recognize that their construct could be called «selfless love» or «compassion» (Sprecher & Fehr, 2005). The CLS is composed of 21 items on a Likert scale from 1 (*not at all true of me*) to 7 (*very true of me*). There are two forms of the CLS: one for significant others (also including family and friends) and one for strangers and humanity in general. Exploratory factor analysis (EFA) showed that the scale had a unidimensional factor structure. Both forms of the CLS showed good internal consistency.

Santa Clara Brief Compassion Scale (SCBCS; Hwang, Plante, & Lackey, 2008). This instrument was developed to meet the need for a short, quick-to-use tool for detecting the construct of compassion. This scale was developed as an abbreviation of Sprecher and Fehr's Compassionate Love Scale (2005). For the SCBCS, Hwang et al. (2008) choose to use the term «compassion» rather than «compassionate love», as the scale is intended to detect only compassion towards

non-intimate others, including strangers. The SCBCS is composed of five items of the CLS (Sprecher & Fehr, 2005) with items on a Likert scale from 1 (*not at all true of me*) to 7 (*very true of me*). The structure, verified through exploratory factor analysis (EFA), was unidimensional with high internal consistency.

The Compassion Scale (CS-P; Pommier, 2010). According to the conceptualization of gratitude by Pommier (2010), this scale detected six dimensions: Kindness and its opposite Indifference, Mindfulness and its opposite Disengagement, Common humanity and its opposite Separation. This instrument is composed of 24 items on a Likert scale from 1 (*almost never*) to 5 (*almost always*). Confirmatory factor analysis (CFA) confirmed the six-dimensional structure of the scale with a single higher order factor of compassion. The reliability is high for the total score of compassion but not satisfactory for all six dimensions.

Compassion Scale (CS-M; Martins et al., 2013). This scale is configured as a measure of compassion across different domains, underlining in particular the value of social networks and relationships. The scale is composed of ten items on a Likert scale from 1 (*none*) to 7 (*all*). The scale was developed to measure five dimensions of compassion (generosity, hospitality, objectivity, sensitivity, and tolerance across social networks and relationships) but the conducted factor analyses did not confirm the proposed five-factor structure, supporting a bifactorial solution. All items beginning «How much of your...?» loaded onto one factor and all items beginning «How many times would you...?» loaded onto the second factor. Internal consistency was found to be acceptable.

Compassion Scale (CS; Gu et al., 2017). On the basis of the review of literature conducted by Strauss et al. (2016), Gu et al. (2017) developed the Compassion Scale (CS), which allows the five constituent dimensions of the construct that emerged from literature to be detected. These are: Recognizing suffering, Understanding the universality of suffering, Emotional connection, Tolerating uncomfortable feelings, and Acting to help/alleviate suffering. Through a series of exploratory factor analyses, the authors obtained a version comprising 22 items with responses on a Likert scale from 1 (*not at all true of me*) to 7 (*completely true of me*) and five dimensions. This five-factor model was also verified through a confirmatory factor analysis that supported this structure of the scale. The internal consistence for the total score and the five dimensions was good.

Regarding detecting the construct of compassion in the Italian context, Italian versions of three of the presented instruments are available, specifically: the Italian version (Di Fabio, 2017b) of the Santa Clara Brief Compassion Scale (SCBCS; Hwang et al., 2008); the Italian version (Di Fabio, 2017c) of the Compassion Scale (CS-M; Martins et al., 2013); and the Italian version (Di Fabio, 2019) of the Compassion Scale (CS; Gu et al., 2017). All these Italian versions showed good psychometric properties in the Italian context aligned with the original version

of the instruments, enabling the construct of compassion to be detected in a valid and reliable manner.

Compassion training

Compassion is recognized as a variable that can be enhanced though specific training (Gu et al., 2017; Jazaieri et al., 2012; Paakkanen et al., 2021). Many different training programmes aimed at increasing compassion have been developed over the years. Purely as examples of the various types of training present in literature, three of them are described in this contribution to enable us to understand better how compassion training is conceived. The first one is a general training programme on compassion, which is widespread in literature and can also be applied to health-care workers (Compassion Cultivation Training, CCT; Jinpa, 2010); the second one is a recent training programme specifically developed for organizational contexts (Emotional Skills Cultivation Training, ESCT; Paakkanen et al., 2021); the third one is a training programme specifically applied in health care and focused on the promotion of leadership characteristics for compassion (Leaders for Compassionate Care Programme, LCCP; National Leadership and Innovation Centre, 2016; Saab, 2019).

Compassion Cultivation Training (CCT; Jinpa, 2010). The CCT programme was developed as a comprehensive compassion training programme that includes a series of techniques for mental and emotional well-being. This programme is based on contemplative practices from the Indo-Tibetan Buddhist traditions and it was developed to cultivate the qualities of compassion for all beings including oneself. The standard CCT programme is administered in eight or nine weeks with sessions of two hours each week. An introductory session before the first session is optional. The contents of each of the nine sessions of the CCT programme are the following: first session (introduction to the course and to settling and focusing the mind); second session (settling and focusing the mind); third session (loving-kindness and compassion for a loved one); fourth session (compassion for oneself); fifth session (loving-kindness for oneself); sixth session (embracing shared common humanity and developing appreciation of others); seventh session (cultivating compassion for others); eight session (active compassion practice); ninth section (integrated daily compassion cultivation practice). When the course is taught in an eight-week format, the second session is not included. The programme is conducted in groups of five to a maximum of thirty-five participants. The effectiveness of the CCT programme was verified in a study (Jazaieri et al., 2013), with pre-test and post-test design and a control group and an experimental group. The experimental group showed an increase in the three domains of compassion (compassion for others, receiving compas-

sion from others, and self-compassion). The CCT programme was also applied to health-care workers, proving effective in reducing work-related burnout and interpersonal conflict, as well as in increasing mindfulness, compassion towards the self, fears of compassion, and job satisfaction (Scarlet et al., 2017).

Emotional Skills Cultivation Training (ESCT; Paakkanen et al. 2021). The ESCT was developed in organizational contexts, starting with the consideration that only meditation-based interventions had been proposed to enhance compassion in organizations. The ESCT was developed considering that the enhancement of emotional skills in managers could improve their compassion. The ESCT includes six modules of three hours across eight weeks. Each module comprised literature, discussions, and exercises developed to provide both didactic and experiential training in emotional skills. In between sessions, the participants were asked to carry out homework exercises. Each module trained emotional skills together with teachings of compassionate motivation. Specifically, the contents of the six modules are the following: first module (increasing the awareness of emotions at work); second module (understanding the forces behind emotions); third module (increasing and strengthening positive emotions); fourth module (facing and dealing with negative emotions and difficult situations); fifth module (leader's toolkit to lead emotions); sixth module (systematically leading the emotional climate of an organization). The effectiveness of the training programme was verified with a pre-test and post-test design among managers, measuring the experimental group and the control group. Results showed that, compared to the control group, the managers in the experimental group showed a significantly increased perception of emotional skills and an increased compassion (Paakkanen et al., 2021).

Leaders for Compassionate Care Programme (LCCP; National Leadership and Innovation Centre, 2016; Saab, 2019). This programme was developed in 2016 by the National Leadership and Innovation Centre in Ireland with the aim of enhancing leaders while supporting their teams in offering high quality and compassionate patient-centred care. The LCCD is articulated over three days. It is based on experiential learning and involves highly interactive sessions conducted in groups. During the first day, after the presentation of the leaders to each other and to the facilitator, the first session «Leading for Compassionate Care» is implemented, aimed at promoting a reflection on the responsibilities and challenges of everyday practice. During the second session of the first day, the concepts of presence and personal impact are explored. Then the third session includes a plenary discussion on the emerging contents regarding leadership for compassionate care delivery. During the second day, the leaders are divided into two groups. The first group works on quality improvement and is equipped with instruments and techniques to promote patient care; the second group is familiarized with co-consulting for building their leadership practice. The third

day, six to eight weeks after the previous ones, starts with a postcard exercise where different images are displayed on cards and leaders have to select two cards (the first one about what has been going on for the leaders since their first day of training; the second one about what they hope to gain from the third day). Then a discussion is conducted where leaders show examples of changes that they have applied in their clinical practice on the basis of the training. After the programme, participants perceived a greater ability in supporting peer learning, managing conflict and building trust with patients. The majority of participants affirmed that they are more able to apply to practice what they had learned from the training and perceived themselves as more motivated to lead in compassionate care delivery (Saad, 2019). A qualitative analysis on LCCD using a semi-structured interview protocol and inductive content analysis showed that participants perceived the programme as innovative because it includes teamwork and networking, contributing to improving the human element of care (Landers et al., 2020).

Compassion, healthy organizations and sustainable leadership

The insecurity of the current working environment aggravated by the Covid-19 pandemic underlines the importance of creating and promoting healthy organizations (Di Fabio, 2017a; Di Fabio et al., 2020). Strength-based prevention perspectives (Di Fabio & Saklofske, 2021) in organizations are focused on promoting workers' resources through early intervention actions that promote personal resources through targeted programmes. This has led to the development and promotion of strength-based prevention perspectives and interventions (Di Fabio & Saklofske, 2014a, 2014b, 2021) centred on variables that can be increased through specific training programmes to support the health and well-being of individuals, workers, teams, leaders and organizations. Compassion is a variable related to health and psychological well-being (Cassell, 2002; Worline & Dutton, 2017) and can therefore be considered as a crucial resource for the promotion of healthy organizations, characterized by culture, climate and practices that create an environment aimed at promoting employee health and safety as well as organizational effectiveness (Di Fabio, 2017a; Di Fabio et al., 2020). A healthy organization leads to healthy and successful business with strong associations between organizational productivity and workers' well-being (Di Fabio, 2017a). Healthy organizations are thus thriving and successful environments characterized by the positive circle of long-term well-being and performance (Di Fabio, 2017a). In this virtuous circle, compassion can be a crucial ingredient. Compassion in the workplace is connected with the relational theory of working (Blustein,

2011) and with the importance of relationships in organizational contexts for the well-being of workers (Allan et al., 2015; Duffy et al., 2016).

In this scenario, in the context of strength-based prevention perspectives, a recent study conducted with Italian workers (Di Fabio & Saklofske, 2021) has linked emotional intelligence (Petrides & Furnham, 2001) with compassion, controlling for the Big Five personality traits. The results of this study showed that trait emotional intelligence explains an incremental percentage of variance with respect to personality traits. Furthermore, trait emotional intelligence mediates the relationship between agreeableness and compassion. If the results of this study are confirmed in future research, emotional intelligence, due to the fact that it can be increased through specific training, could be a crucial preventive ingredient in promoting compassion in organizational contexts (Di Fabio & Saklofske, 2021). The relevance of considering also a primary prevention perspective (Di Fabio & Kenny, 2016; Hage et al., 2017) is underlined as an added value in organizational contexts, for a positive circularity in terms of healthy organizations, healthy business and healthy workers (Di Fabio, 2017a).

In this framework, the value of compassion in organizations also calls for leadership styles. Compassion could be a critical ingredient also in relation to human capital sustainability leadership (Di Fabio & Peiró, 2018), which is centred on «healthy people as flourishing and resilient workers, on healthy organizations as thriving and successful environments characterized by the positive circle of long-term well-being and performance» (p. 3). Human capital sustainability leadership is a higher-order construct (including ethical, sustainable, mindful and servant leadership) evaluated from the leaders' perspective (leaders' version) or from the followers' perspective (followers' version). Ethical leadership aims to «engender fair and just aims, empower an organisation's members, create consistency of actions with espoused values, use behaviour to communicate or enforce ethical standards, fair decisions and rewards, kindness, compassion and concern for others» (Di Fabio & Peiró, 2018, p. 3). Sustainable leadership produces and maintains «lifelong learning, safeguards achievement in the short and long terms, supports others' leadership, includes themes linked to social justice, promotes growth without depleting human and material resources, enhances different abilities and resources towards the well-being of environments, and is also enthusiastically involved in environmental issues» (Di Fabio & Peiró, 2018, p. 3). Mindful leadership is «a style based on paying attention to the present moment and recognizing personal feelings and emotions and keeping them under control, especially under stress; awareness of an individual's own presence at a given time and its impact on other people» (Di Fabio & Peiró, 2018, p. 3). Servant leadership is centred on «the development of human resources, principally considering their interests and not only the advantages for their organizations

or leaders, accepting their answers/requests and supporting them due to a moral responsibility» (Di Fabio & Peiró, 2018, p. 3).

In strength-based prevention perspectives (Di Fabio & Saklofske, 2021), increasable variables, such as trait emotional intelligence (Petrides & Furnham, 2001), are associated with human capital sustainability leadership (Di Fabio & Peiró, 2018). The study by Di Fabio and Svicher (2021) showed that in Italian workers, trait emotional intelligence (Petrides & Furnham, 2001) was able to explain additional variance in human capital sustainability leadership of leaders (Di Fabio & Peiró, 2018), controlling for the effects of personality traits. A greater perception of emotional intelligence in terms of positive emotional resources, control of emotions, recognition of emotions in oneself and in others, and expression of emotions seems to characterize leaders with higher human capital sustainability leadership.

In the same strength-based prevention perspectives (Di Fabio & Saklofske, 2021), increasable variables, such as workplace relational civility (Di Fabio & Gori, 2016), are associated to human capital sustainability leadership of leaders (Di Fabio & Peiró, 2018). In the study by Di Fabio and Gori (2021) in Italian workers, workplace relational civility (Di Fabio & Gori, 2016) was able to explain additional variance in human capital sustainability leadership (Di Fabio & Peiró, 2018), controlling for the effects of personality traits. The perception of leaders to act with greater relational civility (decency, culture and readiness) at the workplace and a greater perception of leaders regarding relational civility from others at the workplace characterized leaders with higher human capital sustainability leadership.

In this framework, also compassion could represent another promising variable in the strength-based prevention perspective (Di Fabio & Saklofske, 2021), in order to favour sustainable management processes and well-being in different organizational contexts. A recent study (Di Fabio, submitted) showed how compassion explained a percentage of incremental variance with respect to personality traits in relation to human capital sustainability leadership (Di Fabio & Peiró, 2018). This study emphasized the value of compassion in leadership styles that promote healthy organizational environments characterized by a positive circle of long-term well-being both for workers and organizations aligned with healthy business.

Compassion and medicine over the years at a glance

The theme of compassion in medicine has been present in scientific literature for many years, with a fluctuating trend. In 1976, Barber, for example, recognized that compassion was considered as an essential matter in medicine, highlighting

its value as a fundamental constituent of care both for physicians and patients. However, the author emphasized that compassion received little attention in medical literature. In the following years, medical literature showed increasing attention to the theme of compassion. In 1983, Pence underlined how scientific medical competences and compassion are not mutually exclusive, supporting the value of increasing and teaching compassion in physicians. In 1995, Dougherty and Purtilo referred to the physician's duty of compassion, emphasizing the importance of having health care systems that protect and encourage compassionate conduct by physicians. Subsequently, Bryan (1999), realizing a historical reflection on the figure of the Canadian physician Sir William Osier, highlighted the value of compassion in medical practice and also of caring «for ourselves and for others within the context of a healthy personality» (p. 284). In 2002, Cassell, in his chapter on compassion in the Handbook of Positive Psychology (Snyder & Lopez, 2002), underlined how compassion is related to suffering and medicine.

In the following years, compassion continued to be considered as a key factor in medical practice. Ekstrom (2012) underlined the relevance of compassion to the appropriate practice of medicine, highlighting how the failures of compassion can lead to poor medical treatment and tragic outcomes. Murison et al. (2013) recommended a new curriculum in pain medicine for medical students, emphasizing the value of possessing both competence and compassion towards their patients. In 2015, Saunders, in the journal Clinical Medicine, considered compassion as a professional issue, highlighting how «its exercise is an essential component of good medical care in many situations and requires grounding in moral principles» (p. 121). Sinclair et al. (2016) proposed a scoping review on health care literature about compassion with forty-four studies included in the analysis. The results of this review showed the limited empirical understanding of compassion in healthcare, emphasizing the absence of patient and family voices in compassion research. It also underlined the necessity to improve patient-reported outcomes through compassionate care through a deeper understanding of the involved key behaviours and attitudes of both patients and health care professionals. The value of compassion in medicine was also emphasized through the contribution by Stergiopoulos et al. (2019) on a lexicon analysis of the concept of humanistic medicine. This contribution examines the utilization and implications of the terminology associated with humanistic medicine. In their analysis, the authors identified two recurring core terms, care/caring and compassion articulated in various psychological, sociological, and political configurations, suggesting the importance of considering compassion in reform agendas for health care systems. Furthermore, the relevance of introducing compassion training in medicine and health care is currently recognized as an issue of great value (Sinclair et al., 2021; Santiago et al., 2022).

Compassion training in medicine and health care

The systematic review offered by Sinclair et al. (2021) presented results on the current state and quality in relation to compassion education interventions. This review aimed to reach the following objectives: first, to carry out a systematic review for examining the present state and quality of available compassion education interventions (e.g., curricula, programmes, workshops, rounds, professional development, lectures, seminars, rotations and training); second, to verify how the different aspects of each education intervention are in line with the different domains of an empirically based clinical model of compassion; third, to recognize the most usual approaches to compassion education.

A biomedical model has traditionally influenced training in medicine and nursing, even if aspects of compassion have been progressively included in the curricula of health care education (Wear & Zarconi, 2008, Willis, 2015). However, current health care training continues to undervalue the need to consider human aspects of medicine and care, such as compassion (Sinclair et al., 2021). The challenge of developing effective compassion training is thus underlined, since compassion is a dynamic, individualized, and complex construct, also taking into account the intrinsic compassionate qualities that learners have before the training (Sinclair et al., 2021).

The conclusion of this systematic review showed that there are various compassion education interventions in health care but that they have a number of limitations in relation to their effectiveness regarding the definition of the construct, the use of self-report measures and the absence of a control group. The authors emphasized the value of grounding the interventions in an empirically based definition of compassion. Furthermore, Sinclair et al. (2021) underlined the importance of overcoming the current state and quality in relation to compassion education interventions. It is also important to take into consideration the compassionate intrinsic qualities that learners have before the training. Starting from this reflection, it is possible to note that learners have a wealth of personality traits, which are considered substantially stable in literature (Costa & McCrea, 1992) and measurable through specific scales, and also characteristics associated with compassion that are amenable to training, such as, for example, emotional intelligence (Di Fabio & Saklofske, 2021). Thus, the review emphasizes the importance of introducing a precision approach to cultivating and sustaining compassion with an advanced perspective supported by empirical research.

Conclusions

The pandemic has altered the precarious balance of healthcare systems already under stress and in many cases already characterized by surplus work. This

alteration could perhaps be irreversible but surely it demands new sustainable solutions to find ways to cope with the imperative challenges. The pandemic has brought about even more serious shortages of health personnel. The pandemic has caused unprecedented burnout and escape from work in general (quiet quitting and the great resignation) but particularly among doctors and healthcare professionals. The digital age is changing and enhancing daily practices as well as the medicine of the future and the helping professions at an exponentially accelerating rate. The challenge of the new paradigm of compassion in 21st century medicine, healthcare and the helping professions is an open road and a great opportunity to be necessarily integrated into the digital age.

A paradigm shift is required (Kuhn, 1962) when a change in the basic assumptions regarding the dominant scientific theory is relevant. So, in this scenario of perturbation, continuous threat, and changes, the paradigm of compassion for medicine, healthcare and the helping professions of the 21st century is a viaticum of sustainability and meaningfulness. This means it facilitates and nurtures identity-making for the professions of this area and provides a path of greater sustainability in terms of identity awareness with concrete outcomes on systems and their positive survival and innovations. Compassion opens the way to the other, starting with the patient and the family members involved, then turning to colleagues and including self-compassion as the initial starting point.

Compassion enacted at an advanced level and inserted in competent technical performance, exploits its adaptive and evolved value in medicine and in the helping professions. It offers new opportunities in the face of loss, pain and suffering (both emotional and physical), as well as changes and new challenges, to more effectively manage any kind of emotional or physical suffering and difficulties. It stimulates resiliency through social support (Cosley et al., 2010) as well as innovation (Brink, 2015). Good relationships nourish the virtuous circle of positive relationality and well-being at the basis of the relational theory of working (Blustein, 2011) and the positive psychology of working (Blustein, 2006, 2013). At the current time, where we are constantly facing new challenges and changes, the value of the new paradigm of compassion in 21st century medicine, healthcare and the helping professions is no longer postponable. It requires research and intervention on solid scientific foundations of the construct, scales and training and the effective and efficient control of the effectiveness of the interventions, in compliance with the principles of accountability (Sexton, Schofield, & Whiston, 1997; Whiston, 2001): intervention effectiveness, services costs and best practices supported by research.

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