the schwartz center
FOR COMPASSIONATE HEALTHCARE

# COMPASSION AS A BUSINESS IMPERATIVE IN HEALTHCARE: A CONVERSATION WITH THE SCHWARTZ CENTER AND MONIGLE

## INTRODUCTION

Dr. Michael Gustafson, Chief Executive Officer of the Schwartz Center for Compassionate Healthcare, and Dave Middendorf, Executive Director of Health, Care, and Wellness at Monigle sat down to discuss what it actually takes to build compassion into a healthcare organization. They cover why getting it wrong impacts burnout, trust, and revenue, and where the industry is headed as AI adoption by both patients and providers accelerates. Their conversation reflects Monigle's partnership with the Schwartz Center, which brought together Monigle's Humanizing Brand Experience model with the Schwartz Center Compassionate Care Scale™ to create the Compassion Index - a new view of how compassion shapes trust, loyalty, and business outcomes in healthcare.

## BUILDING COMPASSION AS A CAPABILITY, NOT A TRAIT

**Question:** The Schwartz Center's work treats compassion as a measurable, trainable, scalable capability rather than something surface-level or innate. What does that path actually look like in practice, and how do organizations know it's working?

**Dr. Michael Gustafson, Schwartz Center for Compassionate Healthcare:** At the individual level, research shows everyone has neural pathways for compassion and empathy, and that with training and support, you can actually build that capability, like strengthening a muscle. Almost everyone going into healthcare already wants to do good; what educators and leaders can do is help reinforce specific skills, like making eye contact, listening, and asking the right questions, that let providers manifest that compassion with patients.

At the organizational level, our Schwartz Compassionate Care Model has six domains that serve as a roadmap for building and sustaining systemic compassion. For example, leaders need to ensure provider well-being, foster patients and families being seen as full humans and not just as diseases, hardwire compassion into systems and processes, and make sure compassion is measured and recognized. As with anything in healthcare, if you don't measure it, it won't be valued and improved. And a key domain is the role of leadership in modelling, investing in and building a culture of compassion.

**Dave Middendorf, Monigle:** What Michael is talking about here is culture, but so often culture is getting oversimplified to a set of value words on a web page, words that describe a feeling without mandating any specific behavior. The Schwartz Center's approach is different: compassion isn't just a value, it's an action. Bridging the gap from nice words to the things you actually do, design, and measure is what closes that gap meaningfully.

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**Question:** How do you measure something like compassion?

**Michael:** The first step was getting consensus on what compassion really means. Compassion means not only understanding and feeling another's suffering, but also taking action to help them. While empathy means feeling or cognitively understanding another's emotions and perspectives, compassion goes further by motivating behaviors to reduce the distress, anxiety or fear. From there, we created the Schwartz Center Compassionate Care Scale, working with patients, focus groups, providers, and national quality and safety experts to define specific behaviors that manifest compassion. We started with 15 to 20 candidate behaviors and validated it down to 12 core ones — concrete actions that providers can take and that patients can perceive and feel. That scale became the basis for the Compassion Index in this study.

**Dave:** For us, it started with proving the impact of brand experience on outcomes the C-suite cares about, since you can't get investment in brand without connecting it to metrics that drive growth. We already had a model showing how these experiences make people more likely to choose an organization. When we built an index around the compassion scale and measured it with consumers this year, we could connect those dots further: how consumers experience compassion directly shapes their choices and their perception of a brand.

## WHAT TRIGGERS ORGANIZATIONS TO TAKE COMPASSION SERIOUSLY

**Question:** The data shows a real cost to getting this wrong — burnout, turnover, lost revenue, medical errors, poor patient adherence, and worse clinical outcomes. When a health system decides to take compassion seriously, what's usually the trigger: a crisis, a leadership change, or something else?

**Michael:** Often it's a crisis: patient experience scores plummeting, a reputational or financial risk tied to transparency, quality and safety issues, or a burnout and staffing crisis. Leaders dig into root causes and often find a lack of compassion is part of the problem. Other times, it's leaders who already see patient experience and compassion as core to their responsibility and advocate to advance compassion proactively as a part of their culture transformation work. Either way, it requires buy-in from the very top to be meaningful.

**Question:** When it's crisis-driven, how hard is it for leaders to name compassion as the issue?

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**Michael:** The usual entry point today is patient experience. The highest-impact questions on surveys overlap heavily with the compassion scale: getting to know patients, supporting them emotionally, understanding the patient's and family's needs. There's also a strong connection to burnout. Burnout and compassion are essentially opposites, so creating an environment where people can deliver compassionate care can reverse burnout and restore the sense of purpose that brought people into healthcare in the first place.

**Dave:** Burnout hasn't gone away; we may be past its peak, but the tail end is persistent. We see it constantly in the work we do: teams want to deliver something new, but that requires people across the organization to change behavior or add to already full plates. We think about behavior as motivation, ability, and prompt; the BMAP model. As Michael mentioned earlier, everyone has the ability to act compassionately, and most organizations are prompting their people to act compassionately, but the meaningful gap in the equation is motivation. Without it, the behavior doesn't follow, and that's where burnout erodes motivation and therefore the behaviors of compassion.

## WHY COMPASSION ISN'T EXPERIENCED EQUALLY

**Question:** Some patient groups report experiencing much less compassion than others, even within the same systems. Is that a training issue, a structural one, or something else?

**Dave**: It's structural. This research made clear that structural inequity was inherently part of our psychographic segmentation, something we hadn't fully recognized before. Some segments are more likely to show up in the hardest settings for healthcare to deliver compassionate care, like emergency rooms and urgent cares, which are high-stakes and chaotic. Others come in already distrustful of the system, so they don't feel considered in how care is framed to begin with. Meanwhile, wellness-minded consumers, generally healthier, higher-income, and more tech-enabled, get quick, easy fulfillment of what they want, which reads as more compassionate.

**Michael:** Segmenting the data around compassion this way hadn't really been done before, and the differences across age groups were striking. We'd tended to think of compassion as one flavor with one set of needs, but people are clearly in very different places. This also overlaps heavily with equity: among the seven consumer segments, access and treatment are far from equal, and we always say that without equitable care, there can't be compassionate care. Understanding everything a patient brings – including their social, demographic, and economic circumstances that we know drive the majority of health outcomes — is essential to providing good clinical care as well as compassionate care.

**Dave:** Closing the gap requires personalization and listening. Naming the gap isn't enough, you have to act on it. In segmentation as a marketing tool, that means recognizing where someone is coming from and communicating with them accordingly.

**Michael:** I was struck by how much the brand-trust questions overlapped with the compassion questions. Certain groups have lost trust in the healthcare system or industry altogether, which makes it much harder to connect and provide compassionate care.

**Question:** So it's less about bias and more about being in situations that make compassion harder to give or receive. An emergency room visit is a very different starting point than a wellness visit.

**Michael:** Right. We're operating in a two-tier American healthcare system: those who can access traditional, well-resourced care, and those who can't. Concierge medicine is an example of that divide. A concierge patient gets 45 to 60 minutes with a provider; it's simply a luxury that not everyone has access to.

## WHAT LEADERS SHOULD TAKE AWAY, AND WHERE THE OPPORTUNITY LIES

**Question:** Looking ahead, what's one thing you each hope healthcare leaders take from this research?

**Dave:** There is a structural pattern here that matters: much of the structure of operating the health system is squeezing compassion out of the process itself, but not out of the people delivering care. It's the classic tension between margin and mission. While much of it is a structural challenge that no single health system can solve on its own, the opportunity is recognizing how compassionate, human experiences make good business sense and that it's necessary to build compassion into operations with the same level of consideration that safety and outcomes get.

**Michael:** Two things stood out to me. First, we now have data showing people leave providers they perceive as uncompassionate, a compelling business case in itself. Second, consumers treat their experience as a proxy for quality and safety, more than the quality metrics the industry has spent years publishing. Combined with existing evidence on outcomes, staffing costs, and malpractice claims, this adds consumer loyalty and decision-making directly to the revenue case for compassion.

**Dave:** There's a wellness angle too. Consumers are increasingly focused on staying healthy, not just seeking care when sick or injured. Growth in that space depends on compassion just as much, arguably more, since wellness is a consumer choice with many alternatives both inside and outside of traditional healthcare.

## AI'S ROLE IN COMPASSIONATE CARE

**Question:** What's your take on AI and compassion, the good, the bad, and the watch-outs?

**Michael:** This is something the industry needs to think about a lot more over the next five years. AI adoption is accelerating fast. The clearest example is ambient documentation: listening to a visit and generating notes automatically, which frees up time providers would otherwise spend typing, whether during the visit (which takes away eye contact) or afterward (adding to workload). That has real potential to reduce burnout and increase face time with patients. There's good early evidence on the provider side, though data on how patients themselves benefit is still thin.

**Dave:** One striking data point from the study: roughly three-quarters of consumers felt AI would make healthcare less compassionate. That's people's instinctive reaction to new technology. But everything in healthcare right now comes down to constraints: time, quality, and cost. And AI's real value is overcoming those constraints. When you ask consumers what they'd actually want AI to help with, it's to help them work around those exact challenges. So, to them, it can look scary at face value, but as they experience the benefits in the places that matter most to them, we could actually see the experience of compassion increase.

**Michael:** Most current AI interventions are invisible to patients, working behind the scenes to help providers be safer or faster. That's different from tools that are directly patient-facing, like something that helps a patient prepare for a visit so the provider can be more effective once they're in the room. The hope is that AI reduces provider burden and creates more time for the human interactions that are the reason people go into medicine.

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## RETHINKING TIME AS A DRIVER OF COMPASSION

**Question:** Time is a foundational driver of compassion, but also one of the most constrained resources. How can leaders rethink the experience of time in care delivery?

**Michael:** Even the most compassionate providers often feel rushed. Evidence shows that as little as 30 to 40 seconds, pausing, making eye contact, and simply asking "what's your primary concern today?", can meaningfully change how a patient experiences a visit. The bigger issue is that patients face long wait times, and then feel the actual visit is never long enough. Both sides need attention.

**Dave:** One study we cited found that simply letting a patient tell their story without interruption changes their perception of time. We also tend to think about time in healthcare too linearly, as a single visit with a clean beginning and end. But anyone can relate to leaving a visit, getting in the car, and having a question pop into their head they forgot to ask, or remembering a symptom they didn't mention. Could an AI tool follow up right after a visit, catch that, and triage it into a real conversation if needed? That'll be interesting to see unfold.

## CLOSING THE GAP BETWEEN WHAT PATIENTS NEED AND WHAT'S DELIVERED

**Question:** The Compassion Index shows that being treated as a person, not just a diagnosis, and getting enough time rank among the top drivers of trust, yet many organizations still struggle with both of these domains. 82% of consumers say they're more loyal to compassionate providers, and many are willing to switch when it's absent. What does that tell us about the gap between what patients need and what's being delivered?

**Dave:** It says a lot, and it goes back to the compassion gap we've talked about: compassionate people, but a less compassionate industry. Designing for compassion just isn't top of mind for most organizations yet. One interesting finding was the difference at a generational level. Gen Z, the youngest consumers we're measuring, are more likely to switch due to a lack of compassion than due to a lack of trust. That's a warning sign, because trust is currently in flux industry-wide, while compassion is something everyone can recognize immediately. As this generation ages into more healthcare needs, that gap could cause real volatility for organizations that aren't ready.

**Question:** Why do you think there's such a generational difference?

**Dave:** Honestly, it's counterintuitive to me, I'd have expected trust to matter more to younger consumers. My guess is this generation has had so much happen to them outside their control that a baseline of distrust is almost assumed going in. Compassion, though, operates on a more human, immediate scale. You can feel compassion from someone you don't fully trust. That may make it a more tangible, currency-like quality for a generation that's grown up skeptical of institutions.

**Michael:** There's another gap worth naming: individual providers get rated far more compassionate than the healthcare industry as a whole. That's a real challenge for hospital leaders, since you only control part of the ecosystem. The larger industry includes everything from insurance companies to care across multiple systems and entities, and all the wellness aspects around it. A single visit can be genuinely compassionate and still leave a patient frustrated with the surrounding experience.

## WHAT TOP PERFORMERS, LARGE AND SMALL, HAVE IN COMMON

**Question:** This year's Compassion Index included both large academic medical centers and smaller community hospitals among the top performers. What does that tell us about what it takes to score well?

**Dave:** Let's start with who shows up as the most trusted. There's a certain inertia to trust: once it's earned there's a sense of longevity and establishment behind it, although it can be wiped out quickly if something drastic happens. A lot of the most trusted brands have been around a long time as enduring institutions in society.

But when you look at the Compassion Index, the top brands are a much more even mix. Compassion comes down more to a human scale, where actions are being evaluated in real time rather than long-held perceptions. You see brands that have shown what compassionate care looks like through the interactions they create, and that can happen at large institutions just as much as at community-based ones.

That's where the growth is going to be: not just in highly acute care moments, but in a more holistic approach to managing people's health and wellness, not just their sickness.

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**Michael:** The common thread is leadership and culture, whether inherited or newly built. That can happen at a small rural hospital or the largest academic medical center, but in every case it takes sustained commitment from leadership and the board to treat it as a strategic priority. It gets harder as systems grow and span more sites and states, but some organizations manage it.

**Dave:** It comes down to a culture of action. Cultures built only on words and ideas don't hold up; the ones that last are designed to reinforce the actions and experiences they claim to value. Simply put, the organization delivers what marketing has promised. That's probably the biggest common thread behind both trust and compassion.

**Michael:** Exactly. "Culture" can sound soft, and people roll their eyes at it, but there are specific, deliberate actions a leadership team can take to reinforce and transform it. It takes planning and patience, but it can happen with the right plan in place.

To explore the full findings behind this conversation, including the Schwartz Center Compassionate Care Scale, the seven consumer segments, and the complete Compassion Index rankings, download Monigle's Humanizing Brand Experience: Healthcare edition, Vol. 9 report.