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The Heart of Healthcare: Development and Initial Validation of 'Malasakit' Scale in Healthcare Services

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Abstract. 'Malasakit' is an innate Filipino identity that manifests through the compassionate actions of healthcare professionals in their patient care, resonating 'Malasakit' throughout our society and culture. This study aims to develop and validate a 'Malasakit' scale by examining the psychometric properties and exploring how 'Malasakit' is perceived and implemented in healthcare settings. A scale of 85 items was given to 130 professionals in various healthcare services. The results of an analysis showed that the initial framework of four factors (Empathy, Care, Compassion, and Concern) was partially confirmed using Exploratory Factorial Analysis. Using the oblique rotation method (Promax) and principal axis factoring estimation, we extracted factors to comprehend variable relationships, ensuring analytical validity. We eliminated 39 of 85 questions with factor loadings below .50. We excluded items with two-factor cross-loadings near .50. Due to persistently low factor loadings below .35, arousal and relax factors were removed. To ensure a stricter scale, all items must share above 0.70 similarities. This strict approach yielded 19 items arranged into two categories. As a key finding, two characteristics emerged: Empathy (Cognitive and Somatic Empathy), found in the literature, and Compassion (Multicultural Competence Care, Reflective Patient-Centered Care, Affective Empathy, and Hospitality), emerging in Filipino health care services. The study found that the scale can assess empathy and care in healthcare services, including factors specific to Filipino healthcare practices.

Keywords: Malasakit; Empathy; Compassion; Reflective care; Healthcare services.

1.0 Introduction

'Malasakit' is an intangible cultural value that molds today's Filipino consciousness. 'Malasakit' is a word that encapsulates the meaning of stewardship, concern, and compassion, which are part of the Filipino character (Habito, 2016). 'Malasakit' is deeply rooted within Filipinos, and it is most commonly acted upon by caring for their families and communities, which often extends to strangers (Redona, 2018). 'Malasakit' enables Filipinos to express empathy and care for others by instituting a strong sense of connection and affinity in the Philippines. The coronavirus pandemic has highlighted both exemplary and detrimental human behaviors. News reports have featured stories of heroism from medical practitioners on the frontlines of the battle against COVID-19, as well as individuals who initiated community pantries for the poor, inspiring others to contribute (Salles, 2022). In this context, 'malasakit' was defined as a combination of two Filipino words: "malasin" (to look) and "sakit" (pain).

Thus, ‘malasakit’ means to observe or recognize the physical, emotional, or spiritual pain of others and strive to alleviate it. (Salles, 2022). Furthermore, it continues to influence Filipino identity. This value has been integral to Filipino culture worldwide (Menguin, 2021).

‘Malasakit’ is seen as a virtue related to compassion. Filipinos are known for being compassionate; this manifests when they side with the ‘underdogs’ (anybody considered a victim) since they know their situations. Furthermore, given that they are aware of their real-life situations, they presume situations subjectively and are easily affected by the unfortunate circumstances of others (Redona, 2018). With that, being able to side with anybody who is a victim and expressing care and empathy even to strangers, as described in Menguin's definition of ‘Malasakit,' amplifies the relation to compassion.

Moreover, it has also been suggested that ‘malasakit’ is a virtue related to empathy. It is similar to creating a strong sense of community and belonging, as described in Menguin's definition of ‘malasakit.’ ‘Malasakit’ has been associated with empathy as its English translation, describing that a person who shows empathy generally takes the perspective of others and is sensitive to their inner perspective (Haslam, 2007). In understanding the concept of empathy in medical practice, according to (James, 2023), establishing an empathic relationship with the patients also leads to fewer disputes (i.e., litigation). It enables healthcare professionals to connect with their patients more humanly. Notably, compassion comes after empathy (James, 2023).

Empathy encompasses the awareness and understanding of other people’s feelings. Compassion, on the other hand, is an emotional response to empathy (James, 2023). A pattern is observed as empathy helps people to understand based on shared humanity, potentially leading to compassion wherein an appropriate response beyond feelings is mediated (Jimenez, 2021). In medicine, both are fundamental in building trust and delivering health care; however, it is significant to note that compassion comes after empathy (James, 2023).

In another perspective, ‘malasakit’ is associated with and often translated as concern for others (Menguin, 2021). Concern is an emotional response of tender feelings toward a distressed other (Davidov et al., 2013). A healthcare provider must be able to identify their patients' concerns in order to provide comprehensive care (Frank, 2017). Concerns and symptoms are not necessarily linked. However, the lack of identification or failure to pay attention to either will affect physician-patient interaction and care delivery success.

‘Malasakit’ is also seen caring for others (Redona, 2018). In addition, Redona defines ‘malasakit’ as the Filipinos' way of saying God cares. The thought of care has a crucial role in the sole identity of healthcare practitioners and is expected to be part of care receivers (Krause et al., 2017). According to Krause, the definition of “care” can be adapted by replacing activity with action, which indicates intentionality and goal-directedness. Overall, ‘malasakit’ is believed to care for others—you care for them, know that you can help, and act on it (Menguin, 2021).

Lastly, Kagandahang loob is a Filipino value that is described as showing genuine kindness to others (Resurreccion, 2007). In its nature, it has varying definitions depending on an individual’s perspective; however, its closest English translation is kindness (Ferrucci, 2006), along with a combination of values such as care, compassion, humility, and patience. Moreover, the study discovered three domains of kagandahang loob, which are 1) ‘Malasakit,’ 2) Pakikipagkapwa, and 3) Malinis na kalooban. ‘Malasakit’ here is described as being sensitive to the needs of others and having the initiative to help without doubt. There is also the presence of considering other's sake, being unmindful of self, and being selfless.

To gain a deeper understanding of the concepts of compassion, empathy, and care concerning ‘malasakit,’ it is essential to explore various theoretical frameworks. These theories will provide a strong foundation and offer a comprehensive perspective on the intricate nuances of these concepts. The first theory is the Emancipatory Theory of Compassion, which states that compassion involves a desire for freedom from suffering by all others that is seen as vital to emancipatory nursing praxis and practice. This theory, which includes patients’ and nurses’ sufferings, moves beyond a nurse-patient relationship to situate suffering and compassion within communities and populations. In this way, it becomes a framework for a more humane and just healthcare system that considers all stakeholders. (Georges, 2013).

Furthermore, the Theory of Empathy focuses on the role of empathy in nurse-patient interactions. This theory particularly shows that empathy comes not only from acquired behaviors or choosing proper words but also from an inherent emotional sensation that facilitates self-identity and the capability to view others in their own shoes. By doing this, nurses can build a rapport with their patients that surpasses cultural boundaries and provides better care (Alligood & May, 2000).

In addition, the cultural care theory fosters diversity and universality, which has become relevant in nursing. It is considered a valuable theory that can assist nurses in their clinical practice and provide culture-specific and culturally congruent nursing care, ensuring the improvement of client care. It is also mentioned that professional care was predicted to exist in all human cultures. On the other hand, care is the physical and spiritual balance, with help, encouragement, and provision adapting to individual situations that contribute to greater health and well-being (Leininger, 1995).

Filipinos have an exclusive perspective called 'Pantayong Pananaw' or, in other words, an independent discourse that only Filipinos can understand, a "we" perspective. According to this theory, this perspective emphasizes a shared experience and internal logic within the Filipino context, using their concepts and language, such as 'Malasakit' and 'Bayanihan.' Furthermore, this is a method of acknowledging the history and development of the nation based on the "internal connectedness and linking of characteristics, values, knowledge, wisdom, aspirations, practices, behavior, and experiences as a unified whole" (Salazar, 1997).

Along with this is the Kapwa Theory, 'kapwa' is a Filipino term used to describe a sense of shared identity. The Kapwa Theory discusses Filipino social interaction and, specifically, answers how people interact with other people. Furthermore, the theory explores the construct of knowing that within interactions, it is known whether it is between a "*hindi ibang tao"* (one of us) or "*an ibang tao"* (not one of us). Regardless, it is emphasized that one should treat both as a kapwa and with a sense of equality, which originates from recognizing a shared identity or a sense of inner self. Moreover, the theory also establishes twelve Filipino values to be considered, with "*kapwa"* or "*pakikipagkapwa"* as the core value from which all other values emanate. (Enriquez, 2004).

In this study, 'Malasakit' is a virtue related to empathy, compassion, care, and concern. It is important to note that one must focus on providing patients with the necessary services while demonstrating the utmost concern for their pain, health status, and financial circumstances. Since there is more money, achievements, and success in healthcare, one may wonder if some or most of them show 'Malasakit' for their patients. In essence, this study aims to develop a scale to understand the concept and application of 'Malasakit' as a process in the context of medicine grounded in the notion that in the field of medicine, achievements, fame, success, and money are established, bringing the researchers to the question, "Do medical practitioners have 'Malasakit?'". The study aims to help the patients understand the concept of 'Malasakit' from the perspective of healthcare professionals and will benefit them by demonstrating that 'Malasakit' helps them understand their feelings and hardships. Identifying the presence or absence of 'Malasakit' can contribute to future research and implementations of programs that can further train healthcare professionals about demonstrating the value of 'Malasakit,' thus paving the way for the betterment of the delivery of healthcare and will benefit the patients.

2.0 Methodology

2.1 Research Design

This study will utilize an exploratory factor analysis research design. It is a measurement model used to identify the structure and dimensionality of the observed data and reveal the underlying constructs that cause the phenomena. This design identifies and examines inter-correlated variables or clusters—called factors or latent variables—. Each observed variable is possibly a measure of every factor; thus, their relationships must be determined (Columbia University Irving Medical Center, 2023). In researching and studying the construct of Malasakit, particularly in developing a psychometric instrument or scale, exploratory factor analysis is the best fit as this study aims to gather and determine factors that will define the concept of Malasakit. Along with this, developing the instrument underwent a reduction of factors or variables, which is important for minimizing errors and ensuring each variable's reliability. Researchers are then expected to interpret and label these factors according to each item included, specifically discussing their conceptual and operational definitions about Malasakit in delivering healthcare (Taherdoost et al., 2014).

2.2 Research Participants

The study was conducted in a private medical institution in an urbanized city in southern Luzon, Philippines. This study's participants are 130 healthcare professionals with past or present experience delivering healthcare in the Philippines; this includes doctors/physicians, registered nurses, pharmacists, physical therapists, and occupational therapists. They should be adults—at least 18 years old following the stated age of majority in Republic Act no. 6809.

2.3 Research Instrument

A questionnaire was used as the instrument of the study, which has been derived from various scales concerning malasakit, specifically compassion, empathy, concern, and care scales. These values have often been correlated to exhibiting malasakit in the healthcare setting. The instrument given to the eligible participants consists of 85 questions that underwent primary and secondary validation from a healthcare professional and psychometrician. Through a questionnaire, the researchers can observe the presence of malasakit in the field and discover its constructs after assessing each factor's multicollinearity. To check the scale's reliability, the researchers used the Cronbach alpha coefficient with a 0.965 reliability index and ensured an item-test correlation of .30 with a value of 0.470 to 0.716.

2.4 Data Gathering Procedure

The desired number of participants in the sample of this research is supported by the studies of Stevens (2003, p. 294) and Hair et al. (p112) Table of Loadings for Practical Significance, which reports the following rules of thumb based on sample size. This Table of Loadings for Practical Significance supports the 130 participants with a 0.60 - 0.75 range of factor loadings in this study, further discussed in the results and discussion section. Once the questionnaire has been created from various scales concerning Malasakit, the researchers will collect data by disseminating the questionnaires to eligible participants online utilizing Google Forms for easier accessibility and distribution during the academic year 2023-2024. This questionnaire first includes an informed consent form, which contains a summary of the study, the significance of the study, and the procedures. Then, they will answer each close-ended question using rating scales. These rating scales align with the 5-point Likert scale—1 as strongly disagree, 2 as disagree, 3 as neither agree or disagree, 4 as agree, and 5 as strongly agree. After collecting data from the survey, the researchers will assess these responses quantitatively; however, they will only serve as additional support for recommendations for future research studies. Descriptive statistics will assess their demographics during this part of the process. Descriptive statistics are derived from the data series, where the distribution of values will be described in the form of averaging, frequency, standard deviation, and percentage (Lee, 2020).

2.5 Ethical Considerations

The study adhered to a rigorous ethical procedure in which participation from professionals was entirely anonymous and voluntary, ensuring strict confidentiality of the responses. With this, a non-coercive recruitment occurred as they were required to provide a signed informed consent before official participation. These guidelines, which are in accordance with ethical regulations, focus on critical principles: (1) Safeguarding against any potential harm, (2) Obtaining clear consent, (3) Maintaining confidentiality, (4) Avoid Deceptive methods, and (5) Allowing participants the option to withdraw at any time. The ethics review committee responsible for approving this study is from the De La Salle Medical and Health Sciences Institute's institutional ethical regulation board, particularly from the Senior High School faculty department. In adherence to the Data Privacy Act of 2012, the data gathered was stored in an Excel file accessible to the researchers. A licensed statistician also had access to the raw and treated data solely to interpret and summarize numerical data; however, after statistical procedures, the file was changed to restricted access. All information the participants gave was handled with confidentiality and was only used to analyze the different factors of malasakit existing in the health workforce. Given that necessary data analysis procedures are completed, all files of the participants' responses have been permanently deleted and are irreversible. Moreover, this rigorous ethical procedure in place effectively to mitigate the risk of discomfort, access to data, and other pertinent factors involving the risk-benefit ratio favorable to the participants

2.6 Data Analysis

Data Analysis is what one would refer to as applying statistical and logical methods to describe, simplify, condense, and recap data to extract meaningful patterns. Shamoo and Resnik (2003) express the idea of analytic procedures as "a set of methods that provide inductive inferences for a data set to distinguish signal (the phenomenon of interest) from noise (statistical fluctuations) present in the data." Data analysis is important in scientific research and business; recently, it has gained extreme importance due to the big demand for data-informed decisions.

The following are the specific objectives of this study:(1) To develop an instrument/scale for Malasakit in healthcare delivery(2) To collate participants' demographic characteristics (3) To determine dimensions, factors, and constructs of Malasakit in healthcare (4) To measure the significant relationship between the demographic profile characteristics and Malasakit. The collected data were subjected to Exploratory Factor Analysis (EFA). EFA is a statistical technique used for data reduction, reducing the data to a smaller set of summary variables and exploring an underlying theoretical structure of phenomena. At this stage, the questionnaire comprised 118 items. After being critically evaluated by three validators, it was finally reduced to 85 items. Upon completing the entire exercise of collecting data through questionnaires, EFA was run twice on this scale, which was further reduced to 46 and then down to the current 26 after ten items had been deleted since their values did not meet the minimum requirements for skewness and kurtosis tests. Afterward, another three items were deleted since they did not significantly load on any of the two identified factors, in addition to losing the Malasakit's scale total size up to 19 items today.

It demanded a rational data interpretation approach, further informing the findings from the researchers' perspective. References to supporting literature are crucial in substantiating the presented ideas. In other words, researchers finally discussed what the findings meant within the framework of their study and whether they were related to the research objectives.

3.0 Results and Discussion

3.1 Demographic Profile

The participants' demographic profile is diverse in terms of age, sex, occupation, type of healthcare provided, and monthly family income. The total number of participants gathered in the study is 130: doctors, nurses, pharmacists, physical therapists, and occupational therapists. It

In terms of age, the participants are mostly early adults. Early adults are those who are around the age of 20 to 40 years old. (CliffsNotes, n.d.). Most participants are 26 to 32 years old, comprising 36.9% (n=48) of the sample. This is followed by 30.0% (n=39) of the participants who fall under the age range of 33 years old to 40 years old. Meanwhile, 13.8% (n=18) are 41 to 48 years old, 9.2% (n=12) are 49 to 56 years old, 8.5% (n=11) are 18 to 25 years old, and 1.5% (n=2) are 65 years old and above.

Regarding sex at birth, 66.2% (n=86) of the participants are female, while 33.8% (n=44) are male. This shows that the sample adequately represents both genders in the target population. Regarding occupation, most of our participants are nurses—comprising 63.1% (n=82) of our gathered participants. As for the rest, 24.6% (n=32) are doctors, 10.0% (n=13) are occupational therapists or physical therapists, and 2.3% (n=3) are pharmacists.

Regarding the type of healthcare service, more than half of the participants are under curative care, representing 38.4%(n=50) of the population. As for the other types of healthcare service, 20.8% (n=27) are under rehabilitative care, 17.7% (n=23) are under palliative care, 13.8% (n=18) are under promotive care, and 9.2% (n=12) are under preventive care. This suggests that the healthcare professionals who participated in this study are focused on providing active treatment and practices to cure patients (e.g., chemotherapy).

Among the participants, 43.1% (n=56) reported a monthly family income of Php 10,000 to 40,000 per month. This suggests that most of the participants have an income lower than P42,000, which is the basic minimum income required to ensure the survival of a family of five members. (The Philippine Star, 2018). As for the rest, 18.5% (n=24) have a salary of more than Php 200,000, 16.2% (n=21) acquire Php 40,000 to 80,000, 10.8% (n=14) garner

Php 80,000 to 120,000, 5.4% (n=7) acquire Php 160,000 to 200,000, 3.1% (n=4) acquire Php 120,000 to 160,000, and another 3.1% (n=4) garner less than Php 10,000 per month.

3.2 Malasakit in Healthcare Delivery

Table 1. Descriptive statistics of Malasakit in healthcare delivery

Items	M	CI	SD	Interpretation
M1. Just by looking at my patient's current state, I know if they are feeling sad.	4.185	[4.1058-4.311]	0.734	High
M2. Just by observing my patient's nonverbal cues, I can identify whether my patient is feeling angry.	4.431	[4.316-4.546]	0.670	Very high
M3. Just by observing my patient's nonverbal cues, I can identify amusement in my patient.	4.308	[4.193-4.423]	0.669	Very high
M4. Just by seeing or hearing my patients, I can feel whenever they are frightened.	4.323	[4.209-4.437]	0.661	Very high
M5. Just by observing my patients, I am able to perceive if they are feeling calm.	4.354	[4.354-4.471]	0.680	Very high
M6. Just by observing my patients, I am able to perceive if they are feeling dissatisfied.	4.338	[4.222-4.455]	0.677	Very high
M7. Just by seeing or hearing someone, I am able to know if they are feeling embarrassed.	4.254	[4.123-4.385]	0.761	Very high
M8. I am open to receiving feedback from my patients for the betterment of my approach to the treatment I deliver.	4.623	[4.529-4.717]	0.547	Very high
M9. I am open to consulting with other healthcare providers about my approach to treating my patients.	4.623	[4.532-4.715]	0.532	Very high
M10. I am eager to acquire and implement additional methods to improve the care and treatment I offer to my patients.	4.623	[4.527-4.719]	0.561	Very high
M11. I demonstrate empathy and understanding towards patients and their families during their healthcare journey.	4.446	[4.341-4.551]	0.611	Very high
M12. As a healthcare provider, I always show respect to both the patient and their family in patient-centered care.	4.677	[4.591-4.763]	0.501	Very high
M13. I demonstrate respect and understanding for patients' cultural and religious beliefs.	4.700	[4.618-4.782]	0.477	Very high
M14. As a healthcare provider, I would maintain eye contact and project a genuine smile to convey approachability during interactions with patients.	4.508	[4.404-4.611]	0.600	Very high
M15. I strive to support patients in times of need. I use empathic actions to help them navigate difficulties and reassure them that I, their healthcare provider, is there for them.	4.400	[4.502-4.298]	0.592	Very high
M16. As a healthcare provider, I strive to understand my patients' perspectives and feelings by putting myself in their shoes.	4.431	[4.310-4.552]	0.704	Very high
M17. As a healthcare provider, I am committed to understanding the emotional and psychological experiences of my patients.	4.469	[4.364-4.574]	0.612	Very high
M18. In providing care, I always express concern towards my patients.	4.592	[4.495-4.690]	0.566	Very high
M19. I try to see and treat my patient as a holistic being rather than just a mere person with a disease.	4.654	[4.561-4.746]	0.539	Very high

Note. M refers to the data's mean. CI is the confidence interval, while SD is the standard deviation. Verbal interpretation follows: more than 4.2 - 5 = Very high, more than 3.4 - 4.2 = High, more than 2.6 - 3.4 = Average, more than 1.8 - 2.6 = Low and, 1.8 and less = Very Weak.

The descriptive statistics indicate that the mean values range from 4.185 to 4.700, with 4.185 corresponding to item M1, "Just by looking at my patient's current state, I know if they are feeling sad," and 4.700 corresponding to item M13, "I demonstrate respect and understanding for patients' cultural and religious beliefs." The overall mean is 4.43, suggesting a very high level of "malasakit" with a standard deviation of 0.64 among the participants who are experiencing malasakit in their healthcare delivery.

In addition, the item with the highest mean is item M13: "I demonstrate respect and understanding for patients' cultural and religious beliefs," which suggests that most respondents demonstrate malasakit through respecting and understanding various cultural and religious beliefs. This notion resonates with the findings of (Durieux-Paillard, 2011), emphasizing the significant influence of culture and diversity on clinical practice. The lowest mean, on the other hand, which corresponds to item M1: "Just by looking at my patient's current state, I know if they are feeling sad," suggests that it is challenging for healthcare professionals to demonstrate malasakit by feeling sad whenever they look at their patient.

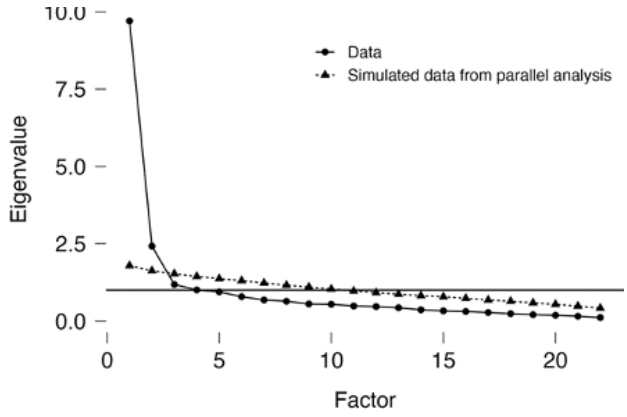

Figure 1. Scree plot

This figure represents the scree plot with corresponding plotted eigenvalues—the measure of the amount of variance accounted for by a factor. This is utilized to visually determine the number of factors by observing the point of inflection (where the curve flattens) of the factors. Observing Figure 1, there are two points in the steep curve before the line trend begins to flatten; hence, two observed factors account for most of the data's total variability, with both having eigenvalues greater than 1. Considering that only the first two factors are plotted above their corresponding simulated data, it is interpreted and validated that only two factors will be extracted. The remaining factors are deemed non-meaningful as they account for a small proportion of the total variability.

Table 2. Factor Loadings

	Factor 1	Factor 2	Uniqueness
M33	0.826		0.389
M34	0.810		0.466
M30	0.804		0.387
M31	0.753		0.462
M42	0.752		0.415
M32	0.716		0.552
M41	0.693		0.458
M35	0.675		0.533
M40	0.666		0.550
M37	0.636		0.511
M44	0.608		0.587
M38	0.607		0.553
M13		0.902	0.266
M10		0.899	0.341
M9		0.799	0.371
M15		0.765	0.411
M12		0.737	0.431
M8		0.723	0.503
M14		0.686	0.366
M1			0.732
M4			0.810
M29			0.660

Note: Applied rotation method is promax.

Looking at Table 2, it is evident that two factors result from executing the exploratory factorial analysis. The main objective of factorial analysis is data reduction—condensing numerous observed variables or indicators into a smaller set of linear composites referred to as components, variates, underlying or latent dimensions, or more commonly known as factors (Peterson, 2000). Initially, the researchers assumed four factors and calculated factor loadings. The researchers excluded items with factor loadings below .50, removing 39 out of 85 questions. The researchers also excluded items with close to .50 cross-loadings on two factors. Further refinement included removing items related to arousal and relax factors due to consistently low factor loadings below .35. To ensure a stricter scale, recommendations by MacCallum et al. (1999, 2001) were followed, requiring all items to have

commonalities over 0.60 or an average communality of 0.70. This thorough process led us to a final set of 19 items associated with the malasakit scale, organized into two factors.

As stated by (Hair et al., 1998), factor loadings exceeding ±0.30 are deemed to meet the minimal significance level. Loadings of ±0.40 are considered more significant, while those reaching ±0.50 or higher are considered practically significant. As the table indicates, both factors exhibit significant data, ranging from 0.607 as the lowest to 0.753 as the highest in factor 1. On the other hand, for factor 2, the lowest factor loading is 0.686, while the highest is 0.902. In addition, 0.607, the lowest in factor 1, corresponds to item 38, "I strive to support patients in times of need. I use empathic actions to help them navigate difficulties and reassure them that I, their healthcare provider, is there for them." This suggests that healthcare providers may struggle to express empathy and compassion towards their patients through empathic actions. For factor 2, the lowest coefficient corresponds to item 14, which has a significance of 0.686, "Just by observing my patients, I am able to perceive if they are feeling dissatisfied." This indicates that healthcare providers may struggle to discern whether their patients are dissatisfied solely through observation. Although these factors may rank lowest, they are still deemed significant. According to Hair, Anderson, Tatham, and Black's study in 1998, any factors reaching a correlation coefficient of ±0.50 or higher are deemed practically significant. Furthermore, 0.753 as the highest in factor 1, corresponds to item 31, "I am open to consulting with other healthcare providers about my approach to treating my patients." This indicates that the participants are encouraged and motivated to collaborate with other healthcare providers to explore effective treatment options for their patients. Lastly, item 13 has the highest coefficient in factor 2, "Just by observing my patients, I am able to perceive if they are feeling calm." This suggests that healthcare providers are more capable of perceiving if their patients feel calm than dissatisfied through observation. Similar to the lowest coefficients, the highest coefficients in factors 1 and 2 are deemed significant, as these coefficients exceed ±0.50.

Based on Table 2 for factor loadings, two factors were determined, consisting of twelve items for factor 1 and seven items for factor 2, with 19 questions. Each factor represents a construct of malasakit in the context of healthcare services. To ensure the factors and their corresponding items, CFA was conducted to construct an adjusted structural model. According to Tavakol and Wetzel (2020), the model supports a causal relationship between the factors and instrument items, leading to elaborate data analysis on each construct or dimension.

3.3 Representation of 2-Factor Loadings and their Meaning

The two identified factors were thoroughly analyzed per item. Factor 1 describes compassion in the context of healthcare through four tenets—specifically, 1) reflective patient-centered care, 2) affective empathy, 3) cultural competence, and 4) hospitality. Under this category, 12 items (items 8-19) are included, all involving an effective response rooted in empathy. Factor 2 is observed to exhibit empathy in the items through specific classifications, which are 1) cognitive empathy and 2) emotional empathy. Seven items (items 1-7) fall under this category, including a type or degree of perception and understanding of a patient's situation.

Compassion. In the healthcare setting, compassion involves a feeling of sympathy or feeling for another's suffering with an emphasis on having a desire to help patients (Point Loma Nazarene University, n.d.). For instance, all four tenets focus beyond empathy, featuring a relational action after recognizing, understanding, and emotional resonance with another's concerns, distress, pain, or suffering, such as offering reassurance and comfort to relieve a patient's anxiety. (Lown, 2016).

Reflective patient-centered care. Patient-centered care establishes a partnership between healthcare professionals and patients to ensure that the patient's needs, wants, and preferences are considered in medical decisions (Shaller, 2007). Furthermore, reflective patient-centered is seen in two of the hallmarks of compassionate healthcare, which are the a) ability to collaborate, communicate, and partner with patients and family members to the extent they need and desire, and b) a commitment of all who provide and support healthcare to communicate and collaborate (American Association of Colleges of Nursing, n.d.). Three items—items 8, 9, and 10—are categorized in this tenet. All three items embody reflective patient-centered care by utilizing the feedback of patients and other healthcare providers to improve the quality of healthcare being provided.

Affective empathy. Recognizing one's emotions through facial expressions, body language, and vocal intonation encompasses the concept of affective empathy. After one has recognized the emotions of others, this evokes an

emotional response to the other person's situation and prompts the accurate identification of one's corresponding emotional state, often through self-reflection and insight (Reniers et al., 2011). Six items fall under the category of Affective empathy on the scale, specifically items 11, 12, 15, 16, 17, and 18. Through these items, one's affective empathy can be assessed by exhibiting empathic behaviors such as showing respect, actively listening, understanding other's experiences, and expressing concern.

Cultural competence. In healthcare, cultural competence is defined as the continuous process of developing knowledge, skills, and attitudes to provide effective and inclusive healthcare, considering the differences of each patient in cultural behaviors, beliefs, and needs (O'Brien et al., 2021). It is realized that understanding a patient's suffering and having the desire to do something with it is made possible through providing culturally competent care (Papadopoulos et al., 2016). With the increasing reports of culturally insensitive care globally, it is essential to go beyond and extend compassion by understanding where they come from and responding appropriately to the patient's wishes and desires (Regis College, 2023). From the improved scale, only item 13 falls under this tenet, which measures healthcare professionals' respect and understanding for diverse cultural and religious beliefs.

Hospitality. To be hospitable is to build relationships and communicate in a supportive and caring manner (Burke, 2023). Hospitality plays a significant role in the healthcare experience by improving patient satisfaction, quality of life, and happiness (Majeed & Kim, 2023). Furthermore, as Burke (2023) stated, hospitality goes beyond being service-minded. It features a holistic approach, seeing each patient in a multi-dimensional sense rather than as a mere case. Hospitality and compassion go hand-in-hand; there is the presence of flexibility such that there is an uncompromised commitment to providing healthcare and establishing a human connection, empowering the patients with confidence and control (Boyd, 2024). Items 14 and 19 fall under this category, with the first focused on building rapport through genuineness and approachability, while the latter focused on viewing patients holistically.

Empathy. Explaining empathy, in general, captures multidimensional psychological constructs all aligned in understanding and being able to feel the positive and negative moments of others (Malakcioğlu, 2022). Empathy as a healthcare value concept encapsulates comprehending the patient's experiences, perspectives, and burdens that shall be reflected in the communication process between the worker and client (Catlow et al., 2020). Empathic interactions are the foundation for trusting worker-patient relationships, enabling them to openly show their perceptions of personal health concerns and even beyond them. This research has also provided insight into why cognitive and emotional empathy constitutes the two tenets of factor 2.

Cognitive empathy. Most questions about the same factor are identified as cognitive empathy, which, on the other hand, is called affective perspective-taking. Abramson et al. (2020) describe it as when a perceiver can accurately perceive or analyze one person's feelings. Included items 1-7, except for item 4, revolve around primarily observing cues from the patient to understand their perceived specific emotions effectively. In the medical field, healthcare professionals such as our participants must actively listen to their client's concerns and consider where their patients are coming from, training them to be sensitive to their emotional states amid their health issues. According to the study of Riess (2017), cognitive empathy should take over when there is a lack of emotional empathy since biases are always present in all settings when there are cultural differences, even in medical care.

Emotional Empathy. In simpler terms, "experience sharing," one can feel and share another's emotions even if the experience has not occurred (Abramson et al., 2020b). The only item classified under this dimension of empathy is Item 4, stating, "Just by seeing or hearing my patients, I can feel whenever they are frightened.". Based on the statement, patient-centered medical professionals are expected to be able to put themselves in their patient's shoes by sharing their burdens and emotions, which can aid in formulating a better overall response during consultations.

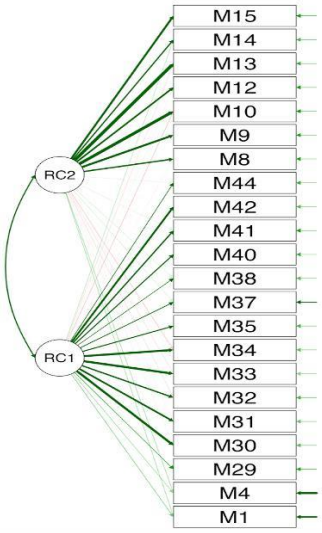

Figure 2. Confirmatory Factor Analysis

Confirmatory factor analysis proceeds EFA as it primarily confirms the discovered factors. Tavakol and Wetzel (2020) state that instrument items are thoroughly tested to extract their underlying internal structure and assess the suitability to the proposed model indicated in Table 6. In this study, the researchers adopted CFA solely to confirm the corresponding items to the factors given in EFA, consisting of 2 dimensions with 12 variables in Factor 1 and 7 in Factor 2. The analysis began with identifying each item's inner construct and grouping factors based on the results. The analysis from statistical data shows that "compassion" (factor 1) encompasses questions from 30-44, while "empathy" (factor 2) comprises items from 8-15.

4.0 Conclusion

The study employed quantitative methods, using Exploratory Factor Analysis (EFA) to collect essential data to address the research question. The two factors identified through EFA were validated using Confirmatory Factor Analysis (CFA). Data were gathered using a questionnaire with established scales that measured affiliated values such as empathy, compassion, care, and concern. Initially comprising 85 items, the questionnaire was refined to 19 questions through multiple rounds of EFA and various statistical tests. The instrument aimed to uncover the underlying constructs and dimensions of 'Malasakit,' providing insights into its application within medical practice.

To further elaborate on the item reduction, the questionnaire with 118 items was given to validators, and after a thorough validation process, 85 items were returned to the researchers. Utilizing the exploratory factor analysis, the 85 items were reduced to 46 items considering the significance level of factor loadings, wherein items with below 0.50-factor loadings will be eliminated. For a stricter process, another EFA was conducted, and from 46 items, the questionnaire was left with only 26 items. Skewness and kurtosis were also utilized to check the degree of asymmetry in a variable's distribution. Of the 26 items, 21 were left after utilizing skewness and kurtosis. Finally, after the scree plot had been utilized to validate the data further, the questionnaire was left with 19 items.

Based on the study's results, in line with the tabulated result for the factors related to 'Malasakit,' there were two dimensions, with 12 variables in Factor 1 and 7 variables in Factor 2. The researchers perceived empathy and compassion as two dimensions of constructing 'Malasakit.' Factor analysis further extracted these dimensions into six tenets with 19 variables. These tenets encompass reflective patient-centered care, affective empathy, cultural competence, and hospitality under compassion. On the other hand, cognitive and emotional empathy is under the category of empathy.

The results made the researchers understand the underlying constructs of 'Malasakit,' further deepening its relationship with empathy and compassion. These two factors play a massive role in the positive effects of healthcare workers' practices and patients' feedback. The researchers also realized how understanding, shared emotion, and empathic actions are essential in demonstrating 'Malasakit' in medical practice. The discovered

tenets are suggested to be incorporated by all healthcare professionals since they promote careful and wiser decision-making, resulting in accurate and appropriate treatment and diagnosis of clients. Along with patient satisfaction, it has also been proven that healthcare workers who exhibit 'Malasakit' as compassion and empathy will foster a sense of purpose and fulfillment in delivering their service, which could further promote a positive light to each part of the medical setting (Coles, 2023).

The research for developing a 'Malasakit' scale has its limitations, which are recommended to be investigated in future research. To begin with, a small sample size was used to conduct the scale's initial development; however, a larger sample size is recommended, such as a 1:5 ratio, where all factor solutions are correct and valid for all measurement scales. With a larger sample size, factor analysis tends to provide more precise estimates of population loadings and is also more stable, or less variable, across repeated sampling (MacCallum et al., 1999). For future research, further investigation on the factors and tenets is suggested to create new terminologies for use, coining new terminologies all about care (Williams et al., 2010). Further investigation of the factors, including their operational definition in a clinical context or their suitability to be used in other countries outside of the Philippines with different cultural values and backgrounds, is highly suggested for future studies. The researchers also recommend future research to conduct an initial pilot testing of the 'Malasakit' scale. This is to take a step further in testing and proving the validity of the developed scale. Future research may involve developing a revised version of the 'Malasakit' scale wherein items benefit different fields and occupations more.

Overall, the study concludes that 'Malasakit' consists of two factors, each encompassing various tenets: empathy and compassion. The 19-item 'Malasakit' scale explores these constructs, assessing the level of 'Malasakit' exhibited by healthcare providers. 'Malasakit' is intangible, not only within Filipino culture but also within the healthcare field.

5.0 Contributions of Authors

LC - conceptualization of the study, writing of the abstract, data analysis, supervising the construction of the paper. LT – conceptualization of the study, editing, writing of the results and discussion; AA- editing, writing of the results and discussion. MA- editing and writing the conclusion. CJ - editing and writing the introduction. JN - editing and writing the methodology.

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7.0 Conflict of Interests

The authors affirm that the research was conducted without any commercial and financial affiliation that might pose a conflict of interest.

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