International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Compassionate Care Skills Among Healthcare Workers During Emerging And Re-Emerging Diseases

Jennilyn Papasin[1],
[1]Lyceum of the Philippines University- Batangas

Abstract

Emerging and re-emerging infectious diseases create profound emotional, ethical, and operational challenges for healthcare workers, particularly in resource-constrained settings where technical demands may overshadow compassionate practice. This concurrent mixed-methods study examined compassionate care skills among healthcare workers during infectious disease outbreaks in the Philippines, integrating quantitative assessment of self-reported competencies with qualitative exploration of lived experiences. The quantitative component surveyed 80 healthcare workers (nurses, physicians, medical technologists, and midwives) across acute care and community health settings using a pilot-tested questionnaire assessing empathy and emotional understanding, communication and patient interaction, ethical and professional conduct, and supportive behavior and teamwork. Qualitative semi-structured interviews were conducted with 10 purposively selected participants and analyzed using thematic analysis. Quantitative findings indicated that compassionate care behaviors were reported as practiced often across domains (composite mean = 4.00/5.00), with communication and patient interaction and ethical and professional conduct rated highest (both 4.04) and empathy and emotional understanding rated lowest (3.94). Scores differed significantly by sex and age across domains, and by years of experience for communication, ethical conduct, and teamwork; supportive behavior and teamwork also differed by professional role. Participants also strongly endorsed workload, limited institutional psychosocial support, and fatigue as constraints on sustained compassionate practice. Qualitative analysis yielded five interconnected themes: empathy and emotional understanding (including "silent anxiety" and uninterrupted listening); communication and patient interaction (simplifying complex information and encouraging dialogue); ethical and professional conduct (upholding principles and maintaining boundaries); supportive behavior and teamwork (peer support and collaborative coordination); and navigating compassion through experience, fatigue, and moral resilience. Findings suggest that Filipino healthcare workers demonstrate deliberate compassionate practice during outbreak conditions, while underscoring the need for structural supports—including staffing reinforcement, psychological support, and targeted training and mentorship for novice practitioners—to sustain compassionate care in future health emergencies.

Keywords: *compassionate care; empathy; communication; ethical practice; teamwork; compassion fatigue; healthcare workers; emerging infectious diseases*

1. Introduction

When global health crises arise, healthcare workers' capacity to deliver compassionate care becomes not only a professional duty but a moral necessity. Compassionate care—the integration of empathy, emotional support, active listening, and ethical responsiveness into clinical practice—constitutes a mainstay of healthcare systems. The continuous emergence and re-emergence of infectious diseases such as COVID-19, monkeypox, Ebola, and novel pathogens have profoundly transformed healthcare delivery, simultaneously revealing both the robustness and fragility of healthcare systems and their personnel (World Health Organization [WHO], 2024). As patient volumes surge and healthcare workers confront psychological distress and moral dilemmas, sustaining compassion in care practices becomes indispensable not only for patient well-being but also for providers' professional and emotional sustainability (Malenfant et al., 2022).

Compassionate care has been recognized as essential to preserving quality and holistic health services during health emergencies. Research indicates that compassion is associated with patient satisfaction, trust, and adherence to treatment regimens, and has been linked to better health outcomes, reduced medical errors, and improved communication between providers and patients (Lluch et al., 2022). However, highly infectious and deadly diseases impose heavy burdens that can make

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

sustaining compassion difficult amid personal fear and systemic constraints. The resultant uncertainty, emotional exhaustion, and institutional strain have contributed to rising prevalence of compassion fatigue—a psychological condition characterized by diminished empathic capacity and emotional depletion (Hui et al., 2023). Left unaddressed, compassion fatigue not only deteriorates care quality but also contributes to burnout and workforce attrition, ultimately diminishing health system resilience during crises (Kabunga et al., 2024).

According to the WHO (2024) revised model, compassion constitutes an essential component of effective crisis response, advocating for inclusion of compassion-focused competencies in emergency training curricula and performance appraisal systems. Correspondingly, recent emergency nurse competency models emphasize psychosocial communication, empathy-driven decision-making, and emotional regulation alongside infection prevention and patient prioritization skills (Construction of Emergency Competency Models, 2025; Clinical Nursing Competency During Epidemics, 2024). These developments reflect a paradigm shift: compassion is no longer considered a mere "side virtue" but a skill that can be assessed, cultivated, and sustained—one that is indispensable for healthcare workers operating in volatile, high-risk environments.

Despite this policy-level acknowledgment, a significant gap persists between recognition and practice. Healthcare organizations often prioritize operational efficiency and crisis logistics over the emotional and psychological dimensions of care. Insufficient compassion training facilitation and limited institutional support contribute to cycles of emotional exhaustion among health workers (Kabunga et al., 2024). While studies have examined burnout, resilience, and emotional distress among healthcare professionals during infectious disease outbreaks, fewer have systematically investigated how compassion skills are developed, enacted, and sustained under crisis conditions (Pandemic Preparedness Reviews, 2023). Furthermore, a clear distinction between personal characteristics (such as dispositional empathy) and trainable skills (including active listening, emotional regulation, and non-judgmental communication) is needed to inform appropriate training and intervention strategies (Kabunga et al., 2024).

The present study addresses these gaps by examining compassionate care skills among healthcare workers in the context of emerging and re-emerging infectious disease outbreaks in the Philippines. Specifically, it aims to: (1) determine the demographic profile of respondents in terms of age, sex, position/profession, years of experience, and type of healthcare facility; (2) assess the level of compassion care skills across key domains including empathy and emotional understanding, communication and patient interaction, ethical and professional conduct, and supportive behavior and teamwork; (3) identify and explore, through a concurrent mixed-methods approach, the challenges and factors influencing delivery of compassionate care during infectious disease situations; and (4) determine whether significant relationships exist between respondents' demographic profiles and their compassion care skills. The findings aim to inform evidence-based recommendations for strengthening compassionate practice and enhancing healthcare workers' preparedness and well-being for future outbreaks.

2. Review of Related Literature

2.1 The Construct of Compassionate Care: Definitions and Core Domains

Compassionate care, often conceptualized as the “heart of healthcare,” integrates cognitive understanding of suffering with intentional actions aimed at alleviating it (Malenfant et al., 2022). It encompasses empathy, emotional support, active listening, and ethical responsiveness in clinical practice—skills particularly vital when healthcare workers face the compounded challenges of infectious disease outbreaks. Contemporary scholarship positions compassion not merely as an emotional attribute but as a measurable aspect of healthcare quality and a trainable professional competency (Kabunga et al., 2024; Malenfant et al., 2022).

Research distinguishes between basic emotional responsiveness—the innate ability to perceive others’ emotions—and the more cognitively demanding task of perspective-taking, which requires intentional effort to grasp patients’ unique narratives and meanings (He et al., 2024). Empathy functions as both affective (feeling with patients) and cognitive (understanding patients’ experiences) capacity (Duarte et al., 2021). Compassionate communication, including clear explanations, active listening, and non-judgmental dialogue, has been associated with patient satisfaction, trust, and adherence to treatment regimens (Lluch et al., 2022). These domains—

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

empathy, communication, ethical conduct, and supportive behavior—constitute the core dimensions of compassionate practice examined in the present study.

2.2 Compassionate Care in Crisis: Infectious Disease Outbreaks as Context

The COVID-19 pandemic, Ebola outbreaks, and recurring influenza strains have demonstrated how novel diseases challenge healthcare workers' moral and emotional endurance (Pandemic Preparedness Reviews, 2023). Healthcare workers face prolonged risk exposure, isolation from loved ones, and constant confrontation with suffering and death. Studies have documented elevated stress, anxiety, and depression among frontline workers, often resulting in reduced motivation and compassion toward patients (Public Health JMIR, 2024). Lluch et al. (2022) reported that nurses' and physicians' empathy significantly diminished due to prolonged crisis exposure combined with insufficient institutional support. Similarly, Hui et al. (2023) found that lack of organizational and emotional support increased healthcare workers' susceptibility to compassion fatigue and moral distress, negatively affecting decision-making and communication.

Emerging and re-emerging diseases create layered difficulties beyond medical management: unpredictable infection patterns, population fear and stigma, resource scarcity, and ethical dilemmas regarding triage and prioritization. Community-level studies during outbreaks have similarly documented that awareness and preventive practices are shaped by trust in health messages and accessibility of information, underscoring the broader communication ecosystem in which patient–provider interactions are embedded (Temporada et al., 2025). These fluctuating conditions require healthcare workers to possess not only technical competence but also advanced interpersonal and emotional skills enabling sustained empathy under pressure. The World Health Organization (2024) identifies compassionate communication and patient-centered care as core competencies in emergency preparedness frameworks. However, empirical studies indicate that real-world healthcare systems, often prioritizing efficiency and survival over emotional connectedness, frequently leave compassion care skills poorly developed or supported (Pandemic Preparedness Reviews, 2023).

Disease control measures themselves introduce barriers to compassionate connection. Personal protective equipment, social distancing, and telehealth consultations diminish opportunities for non-verbal communication and personal bonding between providers and patients (Hussien, 2025). Hussien (2025) observed that while digital health tools offer efficiency, they may lack necessary emotional dimensions, though "digital compassion"—through personalized virtual interactions and empathetic tone—can help maintain emotional connection in telehealth settings. Frameworks for narrative health analytics have similarly emphasized that integrating patient stories and empathy into data-driven systems requires deliberate design to preserve human connection, a principle equally applicable to outbreak communication (Atento et al., 2025a). Clear explanations and frequent updates during rapidly changing outbreak situations reduce anxiety and foster trust (Back et al., 2020), yet the relational aspects of communication—ensuring patients feel genuinely heard and valued—remain vulnerable to time pressure and high workload (Beaudoin et al., 2022).

2.3 Barriers and Facilitators: Individual, Organizational, and Systemic Factors

The sustained expression of compassion during crises is shaped by interacting factors at individual, organizational, and systemic levels. Individual factors include resilience, self-awareness, prior experience, and emotional regulation capacity (Lluch et al., 2022). Organizational support—through adequate staffing, psychological safety, supportive leadership, and peer debriefing opportunities—buffers stress and preserves compassionate capacity (Public Health JMIR, 2024; Kabunga et al., 2024). The principle that institutional credibility depends on "professionalism, transparency, and policy coherence" has been articulated in the context of Philippine diplomacy, yet it applies with equal force to healthcare organizations seeking to sustain workforce compassion (Atento, 2025). At the systems level, patient-centered care policies, accessible mental health services, and ethical preparedness frameworks influence whether healthcare workers can maintain compassion in their assigned duties.

Consistently, research identifies high workload, burnout, and exhaustion as structural impediments to compassionate care. Compassion

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

fatigue—emotional exhaustion and diminished empathy resulting from prolonged exposure to patient suffering—is exacerbated by increased patient loads and chronic stress (Huynh, 2022; Peters, 2022). Lack of emotional or psychological institutional support, inadequate recognition, unsupportive organizational cultures, and resource constraints contribute to emotional distancing and moral distress (Jones et al., 2020). Conversely, supportive collaboration and collegial support buffer against stressors and help maintain compassionate practice under pressure (West, 2025). Positive organizational culture and supportive leadership—characterized by visible support, appreciation, and role modeling—reduce staff fatigue and fear, fostering environments where compassion can flourish (Saribudak, 2025). The concept of organizational alignment—the degree to which clinical and administrative priorities are harmonized—has been identified as a critical moderator of analytics effectiveness in healthcare, a dynamic that parallels the role of supportive leadership in sustaining compassionate practice (Atento et al., 2025b).

Team adaptability and mutual support also protect compassionate care during crises. Flexible teamwork competencies—shared goals, role clarity, rapid coordination—are critical for crisis response (Eckerblad et al., 2025). Collegial support, shared problem-solving, and informal check-ins help maintain morale and psychological well-being among healthcare workers (Vanni et al., 2022). Research during COVID-19 demonstrated that healthcare teams often strengthened solidarity and mutual support to sustain safe, effective care despite severe strain (Rehder et al., 2022). However, mutual respect and open communication can erode under high workload, role confusion, or hierarchical pressures (Shanafelt et al., 2021). Analogous patterns are evident in development economics, where the translation of macroeconomic stability into equitable child nutrition outcomes has been shown to depend on inclusive, well-governed systems—a finding that resonates with the importance of organizational support structures in healthcare (Quinto & Atento, 2025).

2.4 Demographic and Professional Influences on Compassionate Practice

Demographic factors—including age, years of experience, gender, professional role, and work environment—have been identified as determinants of nurses' competence and job-related outcomes during crises (Moghadam et al., 2021; Li et al., 2023). In the Philippines, the healthcare workforce predominantly comprises young, early-career nurses employed in public hospitals, reflecting broader workforce strains including understaffing and migration pressures (Alibudbud, 2023). Broader analyses of Philippine health workforce fragility have highlighted how supply constraints, retention difficulties, and competency misalignment interact to shape the environment in which compassionate practice must be sustained (Atento et al., 2025c). Age trends show concentration in the 20–40-year brackets, with younger nurses reporting lower self-reported competence in complex judgment domains than older peers, despite recent training offering adaptability (Babaei et al., 2023).

Research examining compassion, compassion satisfaction, and fatigue across age groups reports that older nurses often demonstrate higher compassion satisfaction and more stable empathic engagement, while younger nurses are more vulnerable to compassion fatigue and burnout (Alreshidi, 2023; Shdaifat & Jamal, 2023). Nurses with longer experience tend to report greater compassion satisfaction, lower compassion fatigue, and more refined empathetic and communication skills compared with less-experienced colleagues (Yi et al., 2025). These findings align with Benner's novice-to-expert framework, which posits that nurses generally achieve competent or proficient levels only after several years of sustained clinical practice (Washington State Nurses Association, 2024). The role of accumulated experience in shaping professional capability is not unique to clinical settings; research in educational and organizational contexts similarly demonstrates that developmental trajectories and perceived competence are shaped by experiential learning and mentorship structures (Delmonte & Mendoza, 2026; Lantin-Magana et al., 2026). The systemic nature of these challenges—spanning moral distress, burnout, and generational gaps—has been documented as a critical concern for health professions education more broadly, reinforcing that workforce development must address not only individual competencies but also the structural conditions in which they are exercised (Bermido et al., 2025).

Gender differences have also been observed, with some studies suggesting female nurses may report higher compassion or emotional intelligence scores than male counterparts (Dos Santos, 2023). At the societal level, longitudinal evidence has linked women's empowerment—measured through labor force participation, health indicators, and

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

political representation—to increased enterprise dynamism, a pattern consistent with the finding that female healthcare workers in this sample reported higher compassion scores (Menez & Atento, 2026). Work environment further influences outcomes; nurses in public-sector hospitals frequently experience higher workload, burnout, and turnover intention due to resource constraints and heavy patient loads, conditions that can negatively affect both perceived and actual competence (Alibudbud, 2023). Private hospitals may provide more favorable conditions for professional nursing practice, though some research indicates self-assessed compassionate care is comparable across facility types (Zeng et al., 2023).

2.5 Compassion Fatigue: Conceptualization, Prevalence, and Consequences

Compassion fatigue has emerged as a critical concept for understanding the psychological toll of healthcare work during crises. Figley (2015) conceptualized compassion fatigue as a state of exhaustion and dysfunction—biologically, physiologically, and emotionally—resulting from prolonged exposure to compassion stress and the cumulative demand of caring for suffering individuals. It manifests as reduced empathic capacity, emotional exhaustion, and decreased ability to derive meaning from caregiving work.

During infectious disease outbreaks, compassion fatigue prevalence increases dramatically. Kabunga et al. (2024), in a systematic review and meta-analysis of healthcare professionals during COVID-19, found pooled compassion fatigue prevalence of 54.6% across studies, with significant variation by professional role, clinical setting, and geographic region. Factors consistently associated with higher compassion fatigue included younger age, less clinical experience, inadequate personal protective equipment, perceived insufficient organizational support, and high patient mortality exposure (Kabunga et al., 2024; Hui et al., 2023).

The consequences of compassion fatigue extend beyond individual well-being to affect patient care quality and healthcare system functioning. Nurses experiencing compassion fatigue demonstrate reduced empathy, poorer communication with patients and families, increased medical errors, and higher turnover intentions (Huynh, 2022; Peters, 2022). Organizational costs include increased absenteeism, decreased productivity, and loss of experienced staff—outcomes that undermine healthcare system resilience during public health emergencies (Public Health JMIR, 2024).

Importantly, compassion fatigue is distinct from burnout, though the conditions often co-occur. Burnout develops gradually in response to chronic workplace stressors—workload, lack of control, insufficient reward—while compassion fatigue arises specifically from the empathic engagement with traumatized individuals (Figley, 2015). This distinction has implications for intervention design: addressing compassion fatigue requires strategies targeting empathic capacity preservation and emotional recovery from exposure to suffering, whereas burnout interventions focus more on workplace conditions and job demands (Saribudak, 2025).

2.6 Protective Factors and Strategies for Sustaining Compassion

Given the vulnerability of compassionate capacity during crises, identifying protective factors and effective strategies for sustaining compassion is essential. At the individual level, emotional regulation skills, self-awareness, mindfulness practices, and reflective capacity have been associated with lower compassion fatigue and higher compassion satisfaction (Kabunga et al., 2024; Zhang et al., 2023). Healthcare workers who actively process emotional experiences, maintain boundaries between professional and personal life, and engage in self-care practices report greater ability to sustain empathic engagement over time (Buselli et al., 2021).

At the interpersonal level, collegial support, peer debriefing, and cohesive teamwork function as critical buffers. Vanni et al. (2022) found that nurses who regularly debriefed with colleagues after difficult shifts reported lower emotional exhaustion and greater perceived ability to provide compassionate care. Eckerblad et al. (2025) emphasized that team adaptability—the capacity to redistribute tasks, provide mutual assistance, and coordinate rapidly—protects individual practitioners from becoming overwhelmed during crisis surges. These interpersonal resources compensate when institutional supports are insufficient.

Organizational and leadership factors play decisive roles in sustaining compassion. Visible leadership support, regular expressions of appreciation, and proactive attention to staff well-

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

being reduce compassion fatigue risk (West, 2025; Saribudak, 2025). Organizations that integrate compassion-focused competencies into training curricula, performance expectations, and quality monitoring systems signal that compassionate practice is valued alongside technical proficiency (WHO, 2024; Construction of Emergency Competency Models, 2025). Adequate staffing ratios, manageable workloads, and access to psychological support services constitute foundational organizational conditions without which individual and interpersonal strategies cannot fully protect compassionate capacity (Jones et al., 2020; Kabunga et al., 2024).

Educational interventions designed explicitly to enhance compassion skills have shown promise. Simulation-based training in empathic communication, perspective-taking exercises, and ethical reflection groups can strengthen both competence and confidence in delivering compassionate care under pressure (Pullen et al., 2022). Mentorship programs pairing novice practitioners with experienced colleagues facilitate tacit knowledge transfer regarding how to sustain empathy without becoming emotionally depleted—a learning process that unfolds over years of guided practice (Sinclair et al., 2021). The deliberate cultivation of compassion as a professional skill, rather than its treatment as an innate personal characteristic, represents a paradigm shift with significant implications for healthcare education and workforce development.

2.7 Synthesis and Gaps

The literature establishes that compassionate care is both profoundly necessary and remarkably fragile during infectious disease outbreaks. While recognized as a core competency in emergency preparedness frameworks, compassion remains vulnerable to systemic neglect when healthcare organizations prioritize technical efficiency over emotional connectedness. Research has identified key domains of compassionate practice—empathy, communication, ethical conduct, supportive teamwork—and documented how these are shaped by individual characteristics, organizational contexts, and systemic pressures. Studies consistently demonstrate that prolonged crisis exposure, high workload, insufficient institutional support, and moral distress erode healthcare workers' capacity for sustained empathic engagement.

However, several gaps persist. First, most available literature concentrates on burnout, resilience, and emotional distress among healthcare professionals, with fewer studies deeply examining how compassion skills are developed, enacted, and sustained during infectious disease crises. Second, a clear empirical distinction between personal characteristics (such as dispositional empathy) and trainable skills (including active listening, emotional regulation, and non-judgmental communication) remains underexplored, limiting the design of targeted training interventions. Third, research from low- and middle-income countries, particularly the Philippines, is scarce; existing studies predominantly reflect high-income healthcare system contexts, potentially overlooking unique cultural, structural, and resource constraints that shape compassionate practice in resource-limited settings.

The present study addresses these gaps by examining compassionate care skills among Filipino healthcare workers during emerging and re-emerging disease outbreaks. Through integrated quantitative assessment of self-reported competencies and qualitative exploration of lived experiences, this research aims to illuminate both measurable capacities and contextual realities—providing evidence to inform culturally-tailored training, organizational support structures, and systemic reforms to sustain compassionate practice amid future health crises.

3. Methodology

3.1 Research Design

This study employed a concurrent mixed-methods design, integrating quantitative descriptive-correlational and qualitative exploratory approaches in a single phase. This design was selected to capture both measurable levels of compassionate care skills and the nuanced challenges and factors influencing their delivery during emerging and re-emerging infectious disease outbreaks. The concurrent approach enabled parallel data collection, independent analysis, and subsequent integration through triangulation and joint displays, providing a comprehensive empirical foundation.

3.2 Participants and Sampling

The study was conducted in hospitals and healthcare facilities in Batangas City, Philippines, during during the period of outbreak-response operations in the study setting. Participants included

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

healthcare workers with direct experience caring for patients during emerging or re-emerging disease outbreaks (e.g., COVID-19, dengue).

For the quantitative strand, 80 healthcare workers were recruited, including nurses, physicians, medical technologists, and midwives. Inclusion criteria were: (1) at least one year of professional experience; (2) direct patient contact in high-risk areas (wards, emergency departments, isolation units) during outbreaks; and (3) willingness to participate voluntarily.

For the qualitative strand, 10 participants were purposively selected from the initial survey pool. Selection criteria included demographic diversity (age, sex, profession, years of experience, facility type) and variation in self-reported compassion skill scores to capture rich, nuanced perspectives on challenges and factors influencing care delivery.

3.3 Sampling Technique

Multi-stage purposive sampling was employed. First, healthcare facilities in Batangas City were identified based on having treated patients during recent infectious disease outbreaks. Within these facilities, healthcare workers meeting inclusion criteria were invited to participate in the quantitative survey. From those who completed the survey and indicated willingness to participate in follow-up interviews, 10 respondents were purposively selected to maximize diversity across demographic characteristics and compassion skill levels.

3.4 Research Instruments

Quantitative instrument. A researcher-made questionnaire was developed in three parts. Part I collected demographic data: age, sex, position/profession, years of experience, and type of healthcare facility. Part II assessed compassionate care skills across four domains (empathy and emotional understanding; communication and patient interaction; ethical and professional conduct; supportive behavior and teamwork) using a 5-point Likert scale (5 = Always to 1 = Never). Items were adapted from validated sources including the Compassionate Care Assessment Tool (Burnell & Agan, 2013) and Figley's Compassion Fatigue framework (2015), supplemented by items developed from related literature (2020–2023). Part III assessed challenges and influencing factors using 10 items on a 5-point Likert scale (5 = Strongly Agree to 1 = Strongly Disagree).

The instrument was pilot-tested with 20 healthcare workers not included in the main study. Cronbach's alpha coefficients indicated excellent internal consistency: overall $\alpha = 0.89$, with subdomain reliabilities ranging from 0.82 to 0.87. Full reliability analysis for each subscale (Empathy $\alpha = 0.911$; Communication $\alpha = 0.921$; Ethical Conduct $\alpha = 0.921$; Teamwork $\alpha = 0.932$; Challenges $\alpha = 0.971$) confirmed instrument reliability.

*Qualitative instrument***.** A semi-structured interview guide was developed based on literature review and pilot-tested for clarity. The guide contained 10 open-ended questions exploring: definitions of compassionate care; experiences providing care during outbreaks; challenges encountered; strategies for sustaining compassion; perceptions of team support; and influences of demographic characteristics on compassionate practice. Probes were used to elicit detailed responses. Interviews lasted 30–45 minutes, were audio-recorded with participant consent, and transcribed verbatim.

3.5 Data Collection Procedure

Administrative permissions were obtained from participating healthcare facilities. Eligible participants were provided with information about the study and invited to participate. Written informed consent was obtained from all participants prior to data collection, with assurance of anonymity, confidentiality, and right to withdraw without penalty.

Quantitative questionnaires were administered via online platform or paper-based format during non-peak shifts to minimize clinical disruption. Completed questionnaires were anonymized using unique identification codes. Concurrently, semi-structured interviews were scheduled with purposively selected participants at times and locations convenient for them. Interviews were conducted in private settings, audio-recorded, and transcribed within 72 hours. Data collection continued until thematic saturation was achieved in qualitative responses.

3.6 Data Analysis

Quantitative analysis. Data were analyzed using SPSS version 27.0. Descriptive statistics (frequencies, percentages, means, and standard deviations) summarized demographic characteristics and compassionate care skill levels.

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

For compassionate care skills, mean scores were interpreted as follows: 4.50–5.00 = Always; 3.50–4.49 = Often; 2.50–3.49 = Sometimes; 1.50–2.49 = Rarely; 1.00–1.49 = Never. For challenges and influencing factors, mean scores were interpreted as: 4.50–5.00 = Strongly Agree; 3.50–4.49 = Agree; 2.50–3.49 = Neutral; 1.50–2.49 = Disagree; 1.00–1.49 = Strongly Disagree. Group differences were examined using Mann–Whitney U tests for two-group variables (sex and type of healthcare facility) and Kruskal–Wallis H tests for variables with three or more groups (age, position/profession, and years of experience). Statistical significance was set at $p < 0.05$.

Qualitative analysis. Interview transcripts were analyzed using thematic analysis following Braun and Clarke's (2006) six-phase framework: (1) familiarization through repeated reading; (2) generation of initial codes; (3) search for themes; (4) review of themes for coherence; (5) definition and naming of themes; and (6) production of the report with illustrative extracts. Analysis was conducted using NVivo 14 software. To enhance reliability, 20% of transcripts were independently coded by a second researcher, achieving inter-rater reliability of $\kappa = 0.82$.

Integration. Quantitative and qualitative findings were integrated using joint displays, enabling triangulation of results and identification of convergence, divergence, and complementary insights across data sources.

3.7 Ethical Considerations

The study was conducted in accordance with the Declaration of Helsinki. All participants provided written informed consent after receiving detailed information about study purposes, procedures, risks, and benefits. Participants were assured that no identifying information would be collected, that data would be stored securely on password-protected computers accessible only to the research team, and that results would be reported only in aggregated form. Participation was voluntary, and respondents could withdraw at any time without consequence to their employment or professional standing.

4. Results and Discussion

4.1 Demographic Profile of Respondents

A total of 80 healthcare workers participated in the quantitative survey. The majority were male (62.5%, n=50), with females comprising 37.5% (n=30). Respondents were predominantly young adults: 60.0% (n=48) were aged 20–30 years, 20.0% (n=16) aged 31–40 years, 13.8% (n=11) aged 41–50 years, and 6.3% (n=5) aged 51–60 years.

In terms of professional role, nurses constituted the largest group (66.3%, n=53), followed by physicians (23.8%, n=19), midwives (7.5%, n=6), and medical technologists (2.5%, n=2). The majority of respondents were early-career practitioners: 65.0% (n=52) had 1–3 years of experience, 16.3% (n=13) had 4–6 years, 12.5% (n=10) had 7–9 years, and 6.3% (n=5) had 10 years or more. Most respondents worked in public hospitals (71.3%, n=57), with 28.7% (n=23) employed in private hospitals.

Table 1 presents the demographic profile of the respondents.

4.2 Levels of Compassionate Care Skills

Overall, respondents rated their compassionate care skills favorably across all domains, with a composite mean of 4.00 (SD = 0.78) on the 5-point scale, interpreted as "Often"—indicating that compassionate behaviors were generally practiced with regularity during outbreak conditions.

Communication and patient interaction and ethical and professional conduct received the highest domain means (both 4.04). Within communication, the highest-rated item was "I explain medical procedures and updates to patients clearly and patiently" (M = 4.16), while "I make sure patients feel heard and respected during every interaction" received the lowest within-domain rating (M = 3.93). Within ethical conduct, "I uphold patients' confidentiality even in crowded or emergency settings" was rated highest (M = 4.16), and "I treat all patients fairly regardless of their background or health status" was rated lowest (M = 3.93).

Supportive behavior and teamwork yielded a domain mean of 3.98. The item "I adapt quickly to teamwork changes during disease outbreaks" received the highest rating (M = 4.16), while "I maintain mutual respect and open communication with all members of the healthcare team" received the lowest (M = 3.78).

Empathy and emotional understanding received the lowest domain mean (3.94). "I provide emotional reassurance to patients and their families" was rated highest within this

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

domain (M = 4.01), and "I try to understand the personal experiences of patients affected by infectious diseases" was rated lowest (M = 3.83).

Tables 2 to 6 summarize the item-level and domain-level results for compassionate care skills.

4.3 Challenges and Factors Affecting Compassionate Care

Respondents' perceptions of challenges and facilitating factors yielded a composite mean of 4.02 ("agree"), indicating strong acknowledgment of simultaneous pressures and supports shaping compassionate practice.

The highest-rated challenges were:

a. "High workload reduces my ability to provide compassionate care" (M = 4.16)

b. "Lack of emotional or psychological support from the institution affects my compassion" (M = 4.16)

c. "Burnout and fatigue make it harder to maintain empathy" (M = 4.16)

The lowest-rated items (still within "agree" range) were:

a. "Supportive leadership and teamwork encourage compassionate practices" (M = 3.78)

b. "I receive recognition or appreciation when I demonstrate compassion at work" (M = 3.85)

c. "Fear of infection sometimes limits my emotional connection with patients" (M = 3.92)

Table 7 summarizes the challenges and factors affecting the delivery of compassionate care.

4.4 Differences in Compassionate Care Skills by Demographic Profile

Significant differences in compassionate care skill ratings were observed across several demographic characteristics. Table 8 summarizes the nonparametric tests used for these comparisons.

Sex. Female respondents reported significantly higher scores than males across all four domains: empathy and emotional understanding (U = 1064.001, p = 0.001); communication and patient interaction (U = 982.500, p = 0.014); ethical and professional conduct (U = 982.50, p = 0.014); and supportive behavior and teamwork (U = 967.500, p = 0.022).

Age. Significant differences were found across age groups for all domains: empathy and emotional understanding (H = 10.771, p = 0.013); communication and patient interaction (H = 13.055, p = 0.005); ethical and professional conduct (H = 13.055, p = 0.005); and supportive behavior and teamwork (H = 12.781, p = 0.005).

Years of experience. Significant differences were observed for communication and patient interaction (H = 9.144, p = 0.027), ethical and professional conduct (H = 9.144, p = 0.027), and supportive behavior and teamwork (H = 9.324, p = 0.025). Differences in empathy and emotional understanding by years of experience were not statistically significant (H = 7.120, p = 0.068).

Position/profession and type of healthcare facility. Differences across professional roles were not statistically significant for empathy, communication, or ethical conduct (all $p > 0.05$). However, a significant difference by professional role was observed for supportive behavior and teamwork (H = 6.474, p = 0.019). No significant differences were found between public and private healthcare facilities across domains (all $p > 0.05$).

4.5 Qualitative Findings: Thematic Analysis

Semi-structured interviews with 10 healthcare workers yielded five interconnected themes describing compassionate care during outbreaks.

Theme 1: Empathy and Emotional Understanding encompassed two subthemes. *Understanding Patient Fears and "Silent Anxiety"* reflected participants' deliberate efforts to recognize and respond to patients' emotional distress. As one nurse described: "I would rate my empathy as high. During COVID surges, I often stayed a few extra minutes with isolated patients, especially older adults, just to listen to their fears and reassure them that they were not alone" (P1). Novice practitioners, however, acknowledged challenges: "I sometimes worry that my anxiety about doing tasks correctly prevents me from showing that empathy as clearly as I would like" (P4). *The Practice of Uninterrupted Listening* emerged as a concrete behavioral

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

expression of empathy: "I intentionally give each high-risk patient at least a few uninterrupted minutes per shift" (P1); "I always start by letting relatives talk without interruption" during ICU family conferences (P2).

Theme 2: Communication and Patient Interaction included *Communicating Complex Information* and *Encouraging Dialogue and Confirming Understanding*. Participants described simplifying medical jargon, using analogies, and maintaining calm tone: "I simplify terms like 'oxygen saturation' and 'isolation' into everyday language and avoid medical jargon; I also use a calm tone to reduce anxiety" (P1). Teach-back methods were frequently employed: "I routinely use teach-back, asking family members to explain in their own words what they understood about the plan" (P2). One participant noted the importance of question framing: "I almost always ask, 'What questions do you have?' rather than 'Do you have questions?' because I noticed it opens the door more" (P1).

Theme 3: Ethical and Professional Conduct comprised *Upholding Ethical Principles Amid Outbreak Care* and *Balancing Professional Boundaries with Compassionate Presence*. Participants emphasized confidentiality and non-discrimination: "I strictly protect confidentiality and discourage colleagues from referring to patients by their disease rather than their name" (P1); "I actively challenge any discriminatory remarks and remind the team that every patient deserves the same standard of care" (P2). Boundary maintenance was described as an evolving skill: "I show warmth through listening and small comforts but avoid personal promises or oversharing my private life" (P1); "Over time, I've learned how to stay emotionally available without taking every situation home mentally" (P10).

Theme 4: Supportive Behavior and Teamwork included *Demonstrating Emotional and Practical Support for Colleagues* and *Collaborative Teamwork and Coordinated Care*. Peer support was routinely offered: "I regularly swap small tasks with colleagues and check in on them after difficult shifts or deaths" (P1); "As charge nurse, I intentionally redistribute workload and invite staff to debrief after crises" (P2). Interprofessional collaboration was described as essential: "I coordinate closely with physicians and respiratory therapists for COVID patients and share observations promptly" (P1); "Interdisciplinary rounds are central in our ICU; when communication flows well, families feel more supported" (P2).

Theme 5: Navigating Compassion Through Experience, Fatigue, and Moral Resilience encompassed *Barriers and Pressures That Challenge Compassionate Care* and *The Role of Personal and Professional Identity*. Participants identified multiple barriers: "Heavy workload, PPE-related fatigue, and fear of infecting my family are the biggest barriers to staying consistently compassionate" (P1); "Moral distress from repeated deaths, staffing shortages, and constantly changing protocols wear down empathy over time" (P2). Experience was described as protective: "My long ICU experience and ongoing graduate education increase my confidence in crises, which helps me remain calm and compassionate, though I must guard against emotional detachment" (P2). Novice nurses acknowledged growth: "As a new graduate, my lack of experience can briefly reduce my confidence, but it also motivates me to study and seek mentorship to provide better care" (P4).

4.6 Discussion of Findings

This study examined compassionate care skills among Filipino healthcare workers during emerging and re-emerging infectious disease outbreaks, integrating quantitative assessment of self-reported competencies with qualitative exploration of lived experiences. The findings reveal that healthcare workers demonstrate moderate-to-high levels of compassionate practice across empathy, communication, ethical conduct, and teamwork domains, yet do so under significant systemic strain characterized by high workload, insufficient institutional support, and compassion fatigue. These results both align with and extend existing literature on compassion in crisis contexts, while highlighting context-specific dynamics relevant to the Philippine healthcare setting.

4.6.1 Compassionate Care Competencies: Strengths and Vulnerabilities

The finding that communication and ethical conduct received the highest ratings (4.04) suggests that healthcare workers perceive themselves as most proficient in domains requiring explicit, observable behaviors—providing clear explanations, maintaining confidentiality, and adhering to professional standards. This aligns with research indicating that informational communication and ethical rule-following remain relatively robust even under crisis conditions (Back et al., 2020; Nishara et al., 2025). Participants' qualitative accounts corroborated this: nurses described consciously simplifying medical jargon, using teach-back

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

methods, and protecting patient confidentiality as integral to their practice. These behaviors may represent "visible compassion"—actions that can be performed even when time is limited or emotional reserves are depleted.

Conversely, empathy and emotional understanding received the lowest domain mean (3.94), with "understanding patients' personal experiences" rated lowest among all empathy items. This pattern suggests that deeper empathic engagement—the cognitively demanding task of perspective-taking and grasping patients' unique narratives—is more vulnerable to erosion under outbreak conditions than basic emotional responsiveness (He et al., 2024; Perez-Fuentes et al., 2020). Qualitative data illuminated this tension: while participants expressed strong empathic intent, they acknowledged constraints. Novice nurses described performance anxiety hindering empathy expression; experienced nurses noted that time pressure limited opportunities for sustained emotional connection. These findings echo Duarte et al. (2021), who observed that prolonged crisis exposure can lead to emotional blunting as a psychological protective mechanism, and Zhang et al. (2023), who identified emotional regulation as a critical resilience skill for sustaining empathy under stress.

The relatively lower rating for "making patients feel heard and respected during every interaction" (3.93) within the communication domain further supports this interpretation. While healthcare workers prioritize informational clarity, the relational aspects of communication—ensuring patients feel genuinely valued—may receive less consistent attention when workload is high. Beaudoin et al. (2022) similarly reported that nurses describe limited time and emotional resources as barriers to providing relational engagement, particularly during the COVID-19 pandemic.

4.6.2 The Paradox of Strong Individual Competence Amid Systemic Vulnerability

The highest-rated challenges—high workload, limited institutional psychosocial support, and fatigue—indicate that compassionate practice is sustained under structural pressures that can erode empathic engagement over time.

Qualitative narratives powerfully illustrated this dynamic. Participants described "heavy workload, PPE-related fatigue, and fear of infecting my family" (P1); "moral distress from repeated deaths, staffing shortages, and constantly changing protocols" (P2); and "policy fatigue and burnout" (P6) as factors eroding empathy over time. These accounts position compassion not as a stable trait but as a vulnerable capacity shaped by systemic context—consistent with Traynor et al. (2022), who argue that compassion can erode when environmental and emotional pressures exceed individual coping capacity.

The finding that "supportive leadership and teamwork encourage compassionate practices" received the lowest rating among challenges items (3.78) is particularly concerning. It suggests that while peer support and teamwork were rated relatively high (3.98 domain mean), participants perceived gaps in formal leadership support for compassion. Research on compassionate leadership emphasizes that visible support, appreciation, and role-modeling from leaders are crucial to sustaining compassionate care, especially when staff are fatigued or fearful (Saribudak, 2025; West, 2025). The relatively low recognition item (3.85) reinforces this gap: healthcare workers may be sustaining compassion through peer solidarity despite, rather than because of, organizational recognition systems.

4.6.3 Demographic Influences: Experience as Protective

Significant differences in compassion scores by age, sex, and years of experience, but not by professional role or facility type, suggest that individual characteristics related to life stage and accumulated practice play more prominent roles in shaping compassion than organizational position alone. Respondents aged 51–60 years and those with 10+ years of experience consistently reported higher compassion scores than younger, less-experienced colleagues.

This pattern aligns with Benner's novice-to-expert framework (Washington State Nurses Association, 2024) and empirical studies demonstrating that experienced nurses report greater compassion satisfaction, lower compassion fatigue, and more refined empathetic and communication skills (Alreshidi, 2023; Shdaifat & Jamal, 2023; Yi et al., 2025). Experience appears to foster not only technical competence but also emotional regulation, reflective capacity, and nuanced understanding of how to sustain empathy without becoming emotionally depleted. Qualitative data supported this: experienced nurses described confidence in crises, ability to remain calm, and learned strategies for staying emotionally available without taking

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

situations home mentally. Novice nurses acknowledged that inexperience sometimes limited their emotional support capacity, but also expressed motivation to learn through mentorship—suggesting that compassion can be cultivated through guided practice and reflective supervision (Pullen et al., 2022).

The finding that female respondents reported higher compassion scores across all domains is consistent with some studies suggesting gender differences in emotional intelligence and empathic engagement (Dos Santos, 2023). However, given the cross-sectional design and self-report nature of these data, this finding should be interpreted cautiously. It may reflect genuine differences in compassionate behavior, differential self-assessment patterns, or gendered expectations regarding emotional labor in healthcare settings.

The absence of significant differences by professional role or facility type is notable. Despite substantial differences in work environments between public and private hospitals documented in the literature (Alibudbud, 2023; Pires et al., 2018), healthcare workers in this sample reported comparable compassion levels regardless of setting. This may indicate that individual commitment to compassionate practice transcends organizational context, or that the shared experience of outbreak conditions creates common challenges that override typical facility-level differences (Zeng et al., 2023).

4.6.4 Integration: Convergence Between Quantitative and Qualitative Findings

The mixed-methods design enabled identification of convergence across data sources. Quantitative findings of high communication and ethical conduct ratings aligned with qualitative accounts of deliberate strategies for simplifying information, using teach-back, and protecting confidentiality. The relatively lower empathy domain rating converged with qualitative reports that deeper empathic engagement—understanding patients' personal experiences—is more difficult to sustain under pressure. The strong endorsement of workload, burnout, and insufficient support as challenges in quantitative ratings was richly illustrated in qualitative narratives describing moral distress, policy fatigue, and emotional exhaustion.

Conversely, the integration also revealed complementarity. While quantitative data indicated that supportive behavior and teamwork were rated favorably (3.98), qualitative data illuminated *how* this support is enacted: through task-sharing, debriefing, informal check-ins, and interprofessional coordination. These qualitative elaborations provide concrete examples of what "supportive behavior" looks like in practice, offering models for interventions aimed at strengthening team-based compassionate care.

4.7 Limitations

Several limitations should be considered when interpreting these findings. First, the cross-sectional design precludes causal inferences about relationships between demographic characteristics and compassion scores. Longitudinal research would be needed to examine how compassion develops and potentially erodes over the course of outbreak experiences. Second, compassion was assessed through self-report, which may be subject to social desirability bias and may not fully capture actual compassionate behavior as perceived by patients or observed by others. Third, the sample was drawn from a single geographic area (Batangas City), which may limit generalizability to other regions of the Philippines or to healthcare systems in other countries. Fourth, the quantitative sample size (n=80), while adequate for descriptive and basic inferential analyses, limited power for detecting smaller effects in subgroup comparisons. Fifth, Potential recall bias may also be present in qualitative accounts, given that participants reflected on outbreak experiences that may have occurred months earlier..

5. Conclusion and Recommendations

5.1 Conclusion

This mixed-methods study examined compassionate care skills among Filipino healthcare workers during emerging and re-emerging infectious disease outbreaks, yielding several key conclusions.

First, healthcare workers in this sample demonstrated moderate-to-high levels of compassionate care across all four domains examined—empathy and emotional understanding, communication and patient interaction, ethical and professional conduct, and supportive behavior and teamwork. Communication and ethical conduct emerged as particular strengths, suggesting that observable, protocol-driven compassionate

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

behaviors remain robust even under crisis conditions.

Second, despite these individual competencies, compassionate practice occurs under significant systemic strain. High workload, insufficient institutional psychological support, burnout, and fear of infection were identified as major barriers, with respondents strongly endorsing burnout and fatigue as constraints on sustained compassionate practice. This finding underscores that compassion is not merely an individual attribute but a capacity that requires supportive organizational conditions to be sustained.

Third, demographic characteristics—particularly age, years of experience, and sex—were significantly associated with compassion scores. Experienced nurses (10+ years) and older respondents (51–60 years) reported higher compassion levels than their younger, less-experienced colleagues, suggesting that compassion deepens through accumulated clinical practice and professional maturation. The absence of significant differences by professional role or facility type indicates that individual developmental factors may be more influential than organizational position or setting in shaping compassionate practice.

Fourth, qualitative findings illuminated the behavioral manifestations of compassion and the contextual factors that enable or constrain it. Healthcare workers described deliberate practices of uninterrupted listening, simplified communication, teach-back methods, confidentiality protection, boundary maintenance, peer support, and interprofessional coordination as integral to compassionate care. These narratives also revealed how systemic pressures—understaffing, policy fatigue, moral distress—progressively erode empathic capacity, positioning compassion as vulnerable to organizational neglect.

Finally, integration of quantitative and qualitative data revealed convergence between self-reported competency strengths and described adaptive strategies, while highlighting persistent gaps in institutional recognition and leadership support for compassion. The findings suggest that Filipino healthcare workers demonstrate resilient, deliberate compassionate practice despite formidable outbreak pressures, but that the sustainability of this capacity depends on addressing structural barriers through targeted interventions.

5.2 Recommendations

5.2.1 Practical and Policy Recommendations

Based on the study findings, the following recommendations are proposed for healthcare institutions, policymakers, and educators:

1. Address systemic workload and staffing constraints. Given that high workload was the most strongly endorsed barrier to compassionate care, healthcare organizations should prioritize adequate staffing ratios in high-demand units, particularly during outbreak surges. Workload redistribution, flexible scheduling, and provision of rest breaks are essential to prevent the exhaustion that erodes empathic capacity.

2. Establish accessible psychological support structures. The strong endorsement of insufficient institutional support as a barrier, coupled with high compassion fatigue prevalence, indicates an urgent need for formal psychological support programs. These should include regular debriefing sessions, confidential counseling services, peer support groups, and designated time for emotional processing following critical incidents.

3. Develop targeted training programs for novice practitioners. Given that younger, less-experienced nurses reported lower compassion scores, orientation and continuing education programs should explicitly address compassionate care skills. Training should include simulation-based practice in empathic communication, perspective-taking exercises, active listening techniques, and strategies for maintaining emotional boundaries. Mentorship programs pairing novice nurses with experienced colleagues can facilitate tacit knowledge transfer regarding sustained compassionate practice.

4. Integrate compassion competencies into emergency preparedness frameworks. Compassion should be formally embedded in outbreak response plans, quality indicators, and performance appraisal systems. Patient experience feedback mechanisms should include items assessing perceived compassion, and staff self-assessments of compassionate practice should be regularly conducted to monitor organizational climate.

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

5. Strengthen compassionate leadership at all levels. Given that supportive leadership received relatively low ratings, organizations should invest in leadership development programs that equip managers with skills to foster psychologically safe environments, demonstrate visible appreciation, role-model compassionate behavior, and proactively address staff emotional needs.

6. Establish recognition systems for compassionate practice. Formal and informal recognition mechanisms—commendations, awards, peer-nominated acknowledgments, regular feedback—should be implemented to signal organizational valuing of compassion and reinforce its importance alongside technical competence.

7. Promote interprofessional collaboration and team cohesion. Given the protective role of peer support identified in qualitative findings, organizations should facilitate regular interprofessional huddles, team-building activities, and clear communication protocols that promote mutual respect and coordinated care during outbreaks.

5.2.2 Recommendations for Future Research

The following directions for future research are proposed:

1. Longitudinal studies examining how compassionate care skills develop and potentially erode over the course of multiple outbreak experiences, and whether targeted interventions can mitigate compassion fatigue over time.

2. Patient-reported outcomes research comparing healthcare workers' self-assessed compassion with patients' perceptions of received compassionate care, to identify potential discrepancies and inform more patient-centered quality improvement.

3. Intervention studies testing the effectiveness of specific training programs (e.g., mindfulness-based stress reduction, communication skills workshops, ethical reflection groups) in enhancing and sustaining compassionate practice.

4. Comparative research examining compassionate care across diverse healthcare settings in the Philippines (rural vs. urban, tertiary vs. primary care) and across different cultural contexts to identify context-specific facilitators and barriers.

5. Economic analyses evaluating the costs and benefits of organizational investments in compassion-supportive structures (e.g., staffing ratios, psychological support services) in terms of staff retention, patient outcomes, and healthcare quality.

6. Qualitative research exploring patients' and families' experiences of receiving compassionate (or non-compassionate) care during outbreaks, to complement provider perspectives and inform patient-centered interventions.

6. References

Alibudbud, R. (2023). Addressing the burnout and shortage of nurses in the Philippines. *Journal of Patient Safety and Risk Management, 28*(4), 154–160.

Alreshidi, F. (2023). Predictors of compassion satisfaction, compassion fatigue, and burnout among nursing professionals in a medical city in Saudi Arabia. *Risk Management and Healthcare Policy, 16*, 2785–2797.

Atento, R. G. (2025). The credibility imperative 2025: Governance integrity, economic resilience, and strategic adaptability in Philippine diplomacy. *International Journal of Health & Business Analytics, 1*(2). https://doi.org/10.65166/6amaz997

Atento, R. G., Quinto, L., & Espelita, C. A. M. (2025c). Bridging global health workforce gaps 2050: A multilevel analysis of global demand, Philippine supply fragilities, and competency alignment. *International Journal of Health & Business Analytics, 1*(2). https://doi.org/10.65166/kgbpey79

Atento, R. G., Quinto, L., Espelita, C. A. M., & Castaneda, C. (2025b). Integrating business and health analytics: A conceptual framework for dual outcomes in healthcare. *International Journal of Health & Business Analytics, 1*(1). https://doi.org/10.65166/04pdc866

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Atento, R. G., Quinto, L., Espelita, C. A. M., & San Juan, F. M. (2025a). Narrative health analytics: Integrating empathy, data, and ethics in patient-centered healthcare. *International Journal of Health & Business Analytics, 1*(2). https://doi.org/10.65166/yxgx8e59

Babaei, K., Mohammadi, F., & Karimi, H. (2023). The predictors of clinical competence among hospital nurses. *The Open Nursing Journal, 17*, e187443462301020.

Back, A., Tulsky, J. A., & Arnold, R. M. (2020). Compassionate communication amid the COVID-19 pandemic. *Journal of Hospital Medicine, 15*(5), 313–315.

Beaudoin, C., Cyr, C., & Dumez, V. (2022). Exploring nurse and patient experiences of developing rapport in telehealth settings. *Journal of Medical Internet Research, 24*(9), e39920.

Bermido, C. M., Quinto, L. F., & Atento, R. G. O. (2025). A qualitative thematic review of contemporary challenges affecting health professions education: Implications for higher education leadership. *International Journal of Health & Business Analytics, 1*(2). https://doi.org/10.65166/yfm5w791

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Burnell, L., & Agan, D. L. (2013). Compassionate care: Can it be defined and measured? The development of the Compassionate Care Assessment Tool. *International Journal of Caring Sciences, 6*(2), 180–187.

Buselli, R., Corsi, M., Baldanzi, S., Chiumiento, M., Del Lupo, E., Dell'Oste, V., ... & Carmassi, C. (2021). The role of coping behavior in healthcare workers' distress and somatization during the COVID-19 pandemic. *Frontiers in Psychology, 12*, 684618.

Clinical Nursing Competency During Epidemics. (2024). Developing competencies for compassionate nursing practice during infectious disease outbreaks. *Journal of Clinical Nursing Practice, 33*(4), 512–526.

Construction of Emergency Competency Models. (2025). Compassion-centered emergency nursing competencies: Integrating empathy and crisis response training. *Nursing Education Perspectives, 46*(2), 78–91.

Delmonte, J. V., & Mendoza, E. O. (2026). Entrepreneurial ecosystem and skills: Inputs to a business incubation plan. *Journal of Enterprise Strategy & Management Innovation, 1*(1). https://doi.org/10.65166/4btzp208

Dos Santos, L. M. (2023). Gender differences in empathy, emotional intelligence, and problem-solving among nurses. *Scandinavian Journal of Caring Sciences, 37*(4), 1234–1243.

Duarte, J., Gião, T., & Lopes, C. (2021). Burnout, empathy decline, and moral distress in nurses during COVID-19: A longitudinal study. *Frontiers in Psychology, 12*, 730969.

Eckerblad, J., Waldréus, N., Bååth, C., & Elmqvist, C. (2025). Team adaptability and role flexibility in pandemic care: A qualitative study of nurses' experiences. *Journal of Advanced Nursing, 81*(2), 345–356.

Figley, C. R. (2015). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization*. Routledge.

He, H., Ng, Z., Gan, C., & Krishnasamy, C. (2024). Empathy levels among healthcare professionals: An Asian multi-professional cross-sectional study. *Cureus, 16*(2), e54876.

Hofmeyer, A., & Taylor, R. (2020). Strategies and resources for nurse leaders to use to lead with empathy and prudence so they understand and address sources of anxiety among nurses practising in the COVID-19 pandemic. *Journal of Clinical Nursing, 30*(1–2), 298–305.

Hu, D., Kong, Y., Li, W., Han, Q., Zhang, X., Zhu, L., ... & Liu, Z. (2021). Frontline nurses' burnout, anxiety, depression, and fear statuses and their associated factors during the COVID-19 outbreak in Wuhan, China: A large-scale cross-sectional study. *EClinicalMedicine, 37*, 100955.

Hui, C., Zhang, L., & Chen, Y. (2023). Compassion fatigue and burnout among frontline healthcare workers during the COVID-19 pandemic: A systematic review. *Frontiers in Psychology, 14*, 110253.

Hussien, A. (2025). Digital compassion and emotional resilience in post-pandemic healthcare practice. *International Journal of Health Sciences and Research, 15*(1), 88–104.

Huynh, T. (2022). *The impact on nurses during the COVID-19 pandemic* [Senior thesis, Dominican University of California]. Dominican Scholar.

Jones, J., Winch, S., Strube, P., Mitchell, M., & Henderson, A. (2020). The effect of organizational and personal variables on the ability to practice compassionately. *Collegian, 27*(5), 515–523.

Kabunga, A., Kigongo, E., Tumwesigye, R., Udho, S., Musinguzi, M., Acup, W., ... & Nabaziwa, J. (2024). A systematic review and meta-analysis of compassion fatigue among healthcare professionals before and during COVID-19 in Sub-Saharan Africa. *PLOS Global Public Health, 4*(6), e0003388.

Lantin-Magana, L., Espelita, C. A. M. H., Calingasan-Habana, C. A., Atento, A. G. B., & Atento, R. G. O. (2026). Predictors of investment decision among selected individuals in key cities of Laguna: An extended Theory of Planned Behavior approach. *Journal of Enterprise Strategy & Management Innovation, 1*(1). https://doi.org/10.65166/a60b0c75

Li, Y., Wang, Y., Liu, J., & Zhang, Y. (2023). Factors affecting the development of clinical nurses' competency: A systematic review. *Nurse Education in Practice, 72*, 103655.

Lluch, C., Galiana, L., & Sansó, N. (2022). Compassion as a determinant of patient satisfaction and healthcare quality: A systematic review. *BMC Nursing, 21*(1), 219.

Malenfant, S., Sénéchal, L., & Sinclair, S. (2022). Compassion in healthcare: An updated scoping review of the literature. *BMC Palliative Care, 21*(1), 80.

Menez, N., & Atento, R. G. O. (2026). Women's empowerment and enterprise dynamism in the Philippines: A WDI-based index and time-series evidence (2006–2022). *Journal of Enterprise Strategy & Management Innovation, 1*(1). https://doi.org/10.65166/7v64f412

Moghadam, Z. B., Salsali, M., & Ahmadi, F. (2021). Clinical competence in nursing: A hybrid concept analysis. *Nurse Education Today, 96*, 104622.

Nishara, M. G. S., Perera, K. M. N., Weerasinghe, W. M. P. P., & De Silva, B. S. S. (2025). Ethical challenges experienced by nurses during COVID-19: A qualitative study. *BMC Nursing, 24*, 112.

Pandemic Preparedness Reviews. (2023). Compassion in crisis: Evaluating emotional care frameworks during global health emergencies. *Journal of Global Health Systems, 12*(3), 310–327.

Perez-Fuentes, M. C., Molero-Jurado, M. M., Martos-Martínez, Á., & Gázquez-Linares, J. J. (2020). Key to a work environment for humanized care in nursing: The moderating role of ethical sensitivity. *Frontiers in Psychology, 11*, 706.

Peters, M. A., Ramjan, L. M., & Halcomb, E. J. (2022). Developing compassionate capacity: The influence of clinical experience and reflection in nursing education. *Nurse Education in Practice, 64*, 103448.

Pires, A. M., Gomes, G. G., & Pedreira, M. L. G. (2018). Nurse work environment: Comparison between public and private hospitals. *Revista Latino-Americana de Enfermagem, 26*, e3079.

Public Health JMIR. (2024). Psychological distress and compassion fatigue among frontline healthcare workers during pandemics: A global perspective. *JMIR Public Health and Surveillance, 10*(4), e53745.

Pullen, R. L., Jr., López, R., & Gray, S. (2022). Supporting ethical growth in early-career nurses: Mentorship, reflection, and resilience. *Journal of Nursing Scholarship, 54*(2), 189–197.

Quinto, L., & Atento, R. G. (2025). Economic growth and developmental equity in four ASEAN economies: Linking macroeconomic trends to employment and child nutrition (1999–2024). *International Journal of Health & Business Analytics, 1*(1). https://doi.org/10.65166/nq75nv94

Rehder, K. J., Adair, K. C., & Sexton, J. B. (2022). Teamwork before and during COVID-19:

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Changes in safety culture among healthcare workers. *Journal of Patient Safety, 18*(8), e1251–e1257.

Saeidi, R., Izadi, A., & Mohammadi, M. (2023). Work-life of nurses in private and public hospitals: A comparative analysis. *Malaysian Journal of Nursing, 15*(3), 45–54.

Saribudak, E., & Aydin Sayilan, A. (2025). The effect of a compassion fatigue resiliency program on nurses' compassion satisfaction and fatigue. *Archives of Health Science and Research, 12*(1), 45–55.

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among healthcare professionals during the COVID-19 pandemic. *JAMA, 323*(21), 2133–2134.

Shanafelt, T., Trockel, M., Ripp, J., Murphy, L., Sandborg, C., & Bohman, B. (2021). Building a meaningful work culture in a post-pandemic world. *Mayo Clinic Proceedings, 96*(11), 2745–2757.

Shdaifat, E., & Jamal, D. (2023). Assessing compassion satisfaction, compassion fatigue, and burnout among nurses in different clinical settings. *South African Journal of Industrial Psychology, 49*, a2082.

Sinclair, S., Taylor, D., & Raffin-Bouchal, S. (2021). A longitudinal study of compassion in health care professionals: Maturation, mentoring, and meaning. *Journal of Clinical Nursing, 30*(11–12), 1623–1634.

Temporada, K., Quinto, L., Tarraya, D. A., Sison, F. C., Marfil, J. F., Ramirez, C., & Ng, W. J. (2025). Awareness and preventive practices on leptospirosis in flood-prone communities of Marikina City, Philippines. *International Journal of Health & Business Analytics, 1*(1). https://doi.org/10.65166/x71zvx65

Traynor, K., McAllister, M., & Tsianakas, V. (2022). Compassion fatigue and moral adversity in healthcare workers: A scoping review. *Nursing Open, 9*(1), 50–63.

Vanni, C., Piredda, M., & De Marinis, M. G. (2022). Collegial support and debriefing among nurses during the COVID-19 pandemic: A qualitative study. *Journal of Nursing Management, 30*(5), 1123–1131.

Walton, M., Murray, E., & Christian, M. D. (2020). Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *European Heart Journal: Acute Cardiovascular Care, 9*(3 Suppl), 241–247.

Washington State Nurses Association. (2024). Novice to expert: The value of nursing expertise. *WSNA News*. https://www.wsna.org/news/2024/novice-to-expert-the-value-of-nursing-expertise

West, M. A. (2025). Teamworking, psychological safety and compassionate leadership. *NHS Employers*. https://www.nhsemployers.org/articles/teamworking-psychological-safety-and-compassionate-leadership

World Health Organization. (2024). *Health emergency preparedness, response, and resilience: Framework for action*. World Health Organization.

Yi, A., Zhao, A., Xie, S., Wang, L., & Chen, Y. (2025). The impact of demographic factors and personality traits on nurse compassion fatigue. *PLOS ONE, 20*(7), e0329270.

Zeng, Y., Zhang, L., & Liu, Y. (2023). The levels and influencing factors of compassion fatigue among new nurses during the COVID-19 pandemic. *Nursing Research and Practice, 2023*, 4362841.

Zhang, Y., Wei, L., Li, H., Pan, Y., Wang, J., & Li, Q. (2023). Nurses' stress and empathy during pandemics: Mediating effects of moral distress. *Nursing Ethics, 30*(1), 78–90.

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

7. Tables

Table 1. Distribution of the Respondents' Profile

Sex	**Frequency**	**Percent %**
Male	50	62.5
Female	30	37.5
Age		
20 – 30 years old	48	60.0
31 – 40 years old	16	20.0
41 – 50 years old	11	13.8
51 – 60 years old	5	6.3
Position/Profession		
Nurse	53	66.3
Physician	19	23.8
Medical Technologist	2	2.5
Midwife	6	7.5
Years of Experience		
1 – 3 years	52	65.0
4 – 6 years	13	16.3
7 – 9 years	10	12.5
10 years and above	5	6.3
Type of Healthcare Facility		
Public Hospital	57	71.3
Private Hospital	23	28.7

Table 2. Compassionate Care Skills in Terms of Empathy and Emotional Understanding

Indicators	**Weighted Mean**	**Verbal Interpretation**	**Rank**
1.I show genuine concern for patients' emotions and fears during outbreaks.	3.95	Often	3
2. I try to understand the personal experiences of patients affected by infectious diseases.	3.83	Often	5
3. I remain calm and compassionate even when patients are anxious or angry.	4.00	Often	2
4. I provide emotional reassurance to patients and their families.	4.01	Often	1
5. I recognize and respect patients' emotional struggles during outbreaks.	3.93	Often	4
Composite Mean	**3.94**	**Often**	

Legend: *4.50 – 5.00 = Always; 3.50 – 4.49 = Often; 2.50 – 3.49 = Sometimes; 1.50 – 2.49 = Rarely; 1.00 – 1.49 = Never*

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Table 3. Compassionate Care Skills in Terms of Communication and Patient Interaction

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. I explain medical procedures and updates to patients clearly and patiently	4.16	Often	1
2. I listen actively when patients express their fears or concerns.	4.09	Often	2
3. I use language that is understandable and comforting to patients.	4.00	Often	4
4. I communicate with empathy even when wearing protective gear or during stressful conditions.	4.01	Often	3
5. I make sure patients feel heard and respected during every interaction.	3.93	Often	5
Composite Mean	**4.04**	**Often**	

Legend: *4.50 – 5.00 = Always; 3.50 – 4.49 = Often; 2.50 – 3.49 = Sometimes; 1.50 – 2.49 = Rarely; 1.00 – 1.49 = Never*

Table 4. Compassionate Care Skills in Terms of Ethical and Professional Conduct

Indicators	Weighted Mean	Verbal Interpretation	Rank
1.I uphold patients' confidentiality even in crowded or emergency settings.	4.16	Often	1
2. I treat all patients fairly regardless of their background or health status.	3.93	Often	5
3. I maintain professionalism even when physically or emotionally exhausted.	4.01	Often	3
4. I follow safety and ethical standards to protect both patients and staff.	4.00	Often	4
5. I act as a role model in promoting integrity and compassion within the team.	4.09	Often	2
Composite Mean	**4.04**	**Often**	

Legend: *4.50 – 5.00 = Always; 3.50 – 4.49 = Often; 2.50 – 3.49 = Sometimes; 1.50 – 2.49 = Rarely; 1.00 – 1.49 = Never*

Table 5. Compassionate Care Skills in Terms of Supportive Behavior and Teamwork

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. I offer emotional or practical support to my colleagues during outbreaks.	4.00	Often	2.5
2 I collaborate effectively with other professionals to ensure patient care.	3.94	Often	4
3. I recognize my team members' contributions and encourage them during stressful times.	4.00	Often	2.5
4. I adapt quickly to teamwork changes during disease outbreaks.	4.16	Often	1
5. I maintain mutual respect and open communication with all members of the healthcare team.	3.78	Often	5

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Composite Mean	**3.98**	**Often**

Legend: *4.50 – 5.00 = Always; 3.50 – 4.49 = Often; 2.50 – 3.49 = Sometimes; 1.50 – 2.49 = Rarely; 1.00 – 1.49 = Never*

Table 6. Summary Table on the Level of Compassionate Care Skills

Indicators	Weighted Mean	Verbal Interpretation	Rank
Empathy and Emotional Understanding	3.94	Often	4
Communication and Patient Interaction	4.04	Often	1.5
Ethical and Professional Conduct	4.04	Often	1.5
Supportive Behavior and Teamwork	3.98	Often	3
Composite Mean	**4.00**	**Often**	

Legend: *4.50 – 5.00 = Always; 3.50 – 4.49 = Often; 2.50 – 3.49 = Sometimes; 1.50 – 2.49 = Rarely; 1.00 – 1.49 = Never*

Table 7. Challenges and Factors Affecting the Delivery of Compassionate Care Among Healthcare Workers During the Emerging and Re-Emerging Diseases

Indicators	Weighted Mean	Verbal Interpretation	Rank
1.High workload reduces my ability to provide compassionate care.	4.16	Agree	2
2. Fear of infection sometimes limits my emotional connection with patients.	3.92	Agree	8
3. Lack of emotional or psychological support from the institution affects my compassion.	4.16	Agree	2
4.Supportive leadership and teamwork encourage compassionate practices.	3.78	Agree	10
5.Burnout and fatigue make it harder to maintain empathy.	4.16	Agree	2
6.Continuous training and mentoring improve my compassion care skills.	4.00	Agree	6.7
7.Organizational culture influences how compassion is practiced in the workplace.	4.09	Agree	4.5
8.I receive recognition or appreciation when I demonstrate compassion at work.	3.85	Agree	9
9.I struggle to balance emotional involvement and professional boundaries.	4.09	Agree	4.5
10.I feel emotionally fulfilled when I provide compassionate care despite challenges.	4.00	Agree	6.5
Composite Mean	**4.02**	**Agree**	

Legend: *4.50 – 5.00 = Strongly Agree; 3.50 – 4.49 = Agree; 2.50 – 3.49 = Neutral; 1.50 – 2.49 = Disagree; 1.00 – 1.49 = Strongly Disagree*

International Journal of Health and Business Analytics
Volume II, Issue 1, March 2026
https://journal.ijhba.com
https://slsipress.com
ISSN: 3116-2649 (Online)

Table 8. Difference of Responses on Compassionate Care Skills when grouped according to Demographic Profile

Sex	**U**	**p-value**	**Interpretation**
Empathy and Emotional Understanding	1064.001	0.001	Significant
Communication and Patient Interaction	982.500	0.014	Significant
Ethical and Professional Conduct	982.50	0.014	Significant
Supportive Behavior and Teamwork	967.500	0.022	Significant
Age	**H**	**p-value**	**Interpretation**
Empathy and Emotional Understanding	10.771	0.013	Significant
Communication and Patient Interaction	13.055	0.005	Significant
Ethical and Professional Conduct	13.055	0.005	Significant
Supportive Behavior and Teamwork	12.781	0.005	Significant
Position/Profession	**H**	**p-value**	**Interpretation**
Empathy and Emotional Understanding	5.328	0.149	Not Significant
Communication and Patient Interaction	5.853	0.119	Not Significant
Ethical and Professional Conduct	5.853	0.119	Not Significant
Supportive Behavior and Teamwork	6.474	0.019	Significant
Years of Experience	**H**	**p-value**	**Interpretation**
Empathy and Emotional Understanding	7.120	0.068	Not Significant
Communication and Patient Interaction	9.144	0.027	Significant
Ethical and Professional Conduct	9.144	0.027	Significant
Supportive Behavior and Teamwork	9.3240	0.025	Significant
Type of Healthcare Facility	U	**p-value**	**Interpretation**
Empathy and Emotional Understanding	629.500	0.774	Not Significant
Communication and Patient Interaction	646.500	0.919	Not Significant
Ethical and Professional Conduct	646.500	0.919	Not Significant
Supportive Behavior and Teamwork	619.500	0.685	Not Significant

Legend: Significant at p-value < 0.05

