RESEARCH ARTICLE

Adaptation and validation of a patient-reported compassion measure in the Spanish population: The Spanish version of the Sinclair Compassion Questionnaire (SCQesp)

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Abstract

International practice guidelines and policies recognize compassion as a fundamental dimension of quality care. A key element in enhancing compassion in healthcare settings is having reliable patient-reported experience measures. In the Spanish context, there is a need for a valid Spanish patient-reported compassion measure for use in both research and clinical practice. The Sinclair Compassion Questionnaire (SCQ) represents the gold standard for patient-reported compassion measures in English-speaking settings. The primary aim of this study is to culturally adapt and validate the SCQ in a Spanish population. A Spanish version of the SCQ (SCQesp) was used to collect data from 303 Spanish patients (in two contexts: hospitalized and medical visit). Confirmatory factor analysis confirmed a one-factor solution in the 15-item (SCQesp) and five-item (SCQesp-SF) short form version. The SCQesp showed excellent values of reliability: Cronbach's $\alpha = 0.98$; composite variance = 0.98 (0.905–0.854); and stratified variance = 0.78. The SCQesp-SF showed similar values of reliability. The SCQesp has excellent psychometric properties, making it a valid and reliable measure for assessing compassion in healthcare research and clinical care. This scientifically rigorous and psychometrically robust compassion measure in Spanish could allow healthcare providers, researchers, and leaders to routinely assess compassion.

KEYWORDS
compassion, healthcare, measure, patient-reported measure, Spanish

1 | INTRODUCTION

The importance of including patients in the development and evaluation of quality healthcare is increasingly recognized and emphasized by leading international health authorities, who recognize that without patient engagement and the development of patient-reported instruments, it is impossible to move toward quality healthcare that addresses the rights of patients and their families and their needs (Kuipers et al., 2019; Sikka et al., 2015; Sinclair et al., 2022). As a result, patient-reported outcomes (PROs), direct reports

patients provide about their health, quality of life, or functional status associated with their health and healthcare, have become increasingly relevant (Kingsley & Patel, 2017; Weldring & Smith, 2013). Traditionally, the instruments developed for evaluating PROs have addressed the impact of an intervention, therapy, or service on the patients' health status (Kingsley & Patel, 2017; Weldring & Smith, 2013). Currently, growing international attention is being paid to measures that assess patients' perspectives of their experiences receiving healthcare services (PREMs) and how they impact quality care ratings and patient outcomes (Kingsley & Patel, 2017; Weldring & Smith, 2013).

Notably, the absence of compassion in health care has been linked to (1) poor symptom control, (2) patient complaints, (3) high chronic stress, and (4) medical complications (Levinson, 1997; Lown et al., 2011; Malenfant et al., 2022; Murphy et al., 2009; Neumann et al., 2011; Trzeciak et al., 2017). At the same time, the presence of compassion in healthcare has been linked to (1) greater emotional well-being in patients, (2) improved quality of life, and (3) greater satisfaction with the care received (Crowther et al., 2013; Flocke et al., 2002; Francis, 2013; Heyland, 2006; Lown et al., 2011; McDonagh et al., 2004; Riggs et al., 2014; Sturgeon, 2008; Willis, 2015; Youngsen, 2014). Furthermore, several studies on the quality of care in the healthcare setting indicate that patients identify compassion as one of their most critical unmet needs (Crowther et al., 2013; Francis, 2013; Heyland, 2006; Riggs et al., 2014).

Patient's experience of compassion is increasingly recognized as an essential aspect of quality care (Malenfant et al., 2022; Sinclair et al., 2022; Trzeciak & Mazzarelli, 2019) and the overall patient experience (Beryl Institute, 2018; Lown et al., 2011; Malenfant et al., 2022). Compassion is "a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action" (Sinclair et al., 2016, p. 195). In this sense, compassion is not restricted to physical aspects of health but patients' multifactorial needs: physical, practical, psychological, social, and spiritual (Sinclair, Hack, et al., 2021). International practice guidelines and policies recognize compassion as a fundamental dimension of quality care and, therefore, must be taken into account both in the training of healthcare professionals and healthcare systems evaluation (Canadian Hospice and Palliative Care Association, 1995; Francis, 2013; Papadopoulos & Ali, 2016; Paterson, 2011; Pavlova et al., 2023; Sturgeon, 2008; Thienprayoon et al., 2022).

The significant impact of compassion on various indicators of healthcare quality has led researchers, educators, and policymakers worldwide to consider compassion as (1) a patient right (Paterson, 2011); (2) a core professional competency (American Medical Association, 2001; Institute of Medicine, 2004; Maclean, 2014; Nursing and Midwifery Council, 2015; Sturgeon, 2008), and (3) a standard of care that healthcare organizations, educators, and healthcare providers must be able to implement, measure, evaluate and report on (Department of Health, 2008; Francis, 2013; NHS Commissioning Board, 2012; Papadopoulos & Ali, 2016; Willis, 2015).

A key tool in implementing compassion in healthcare settings is having reliable patient-reported measurement tools (PREMs) to assess patient's experiences of the care they received. These PREMs would allow care teams to modify patient care, analysts to assess associations between compassion and various indicators, variables, and outcomes, and researchers to develop and assess interventions to improve compassion within healthcare. Within English-speaking patient populations, a recent review identified four patient-reported compassion measures that are currently available (Sinclair et al., 2022): (1) the Compassionate Care Assessment Tool© (Burnell & Agan, 2013), (2) the Schwartz Center Compassionate Care Scale™ (Lown et al., 2015), (3) the Five-Item Tool to Measure Patient Assessment of Clinician Compassion (Roberts et al., 2021; Sabapathi et al., 2019), and (4) the Sinclair Compassion Questionnaire (SCQ) (Sinclair, Hack, et al., 2021). Within Spanish-speaking patient populations, a recent systematic review (Soto-Rubio et al., 2023) identified that there are currently no valid and reliable Spanish-validated patient-reported compassion measures.

Utilizing a valid and reliable measure for evaluating patient-reported outcome measures (EMPRO) (Valderas et al., 2008), the SCQ was the only compassion measure that met the EMPRO's threshold for a valid and reliable measure. Moreover, the SCQ achieved perfect EMPRO scores for the subscales of internal consistency, reliability, validity, and respondent burden (Sinclair, Hack, et al., 2021). As a result, the SCQ is considered the "gold standard" measure for conducting compassion research and assessing patients' experiences of compassion (Sinclair, Kondejewski et al., 2022).

The compassion model proposes five essential elements of compassion: (1) *virtuous response*: the noble qualities of healthcare providers that motivate an initial response to a person experiencing suffering; (2) *relational space*: interpersonal aspects of compassion that emanate from healthcare providers and establish a human connection; (3) *seeking to understand*: attempting to understand the patient as a person and their unique needs; (4) *relational communication*: verbal and nonverbal displays of compassion conveyed through clinical communication; and (5) *attending to needs*: a timely and attuned desire to actively address a person's multifactorial needs (Sinclair et al., 2016). The 15-item SCQ was developed adhering to strict measure and development guidelines through a systematic process of item generation (Sinclair et al., 2020), initial validation through a Delphi panel of subject matter experts and cognitive interviews with patients (Sinclair, Jaggi, Hack, Russell, McClement, Cuthbertson, Selman, et al., 2020), and an exploratory and confirmatory factor analysis (CFA) of 633 patients to comprehensively assess the psychometric properties of the measure. Factor analyses demonstrated a single-factor solution. While comprised of five theoretical domains of compassion, these are subsumed under a single latent construct of compassion (Sinclair, Hack, et al., 2021). A separate secondary analysis demonstrated the reliability and validity of a five-item short-form version (SCQ-SF), also revealing a single factor of compassion and strong factor loadings. This short form provides further flexibility and utility to clinicians and survey administrators wanting to embed a measure of compassion in their clinical assessments and patient/family surveys without compromising psychometric rigor (Sinclair, Hack, et al., 2021).

The SCQ was developed from the compassion model (Sinclair et al., 2016), which was empirically constructed from patient interviews and has since been validated in various patient populations, including but not limited to pediatrics (Sinclair, Kondejewski, et al., 2020; Sinclair, Raffin-Bouchal, et al., 2021), residential care (Smith-MacDonald et al., 2019), and acute care and hospice (Sinclair, Hack, et al., 2021). The SCQ is also available in French and Mandarin (Boss et al., 2023; Chu et al., 2022; Sinclair, Hack, et al., 2021; Sinclair et al., 2018; Singh et al., 2020; Smith-MacDonald et al., 2019).

Thus, the main objective of this study was to adapt and validate the original and the short version of the SCQ within a Spanish population.

2 | METHODS

2.1 | Participants

The initial sample consisted of 361 patients from various medical settings in Valencia, Spain, from September 1, 2021, to July 31, 2022 (Table 1). The Ethics Committees of the participating centers approved this study. The inclusion criteria were being older than 18 years at the time of the study, having the cognitive ability to answer the questionnaire, having Spanish as their mother tongue, and having had a sufficient amount of contact with the healthcare system. The latter criteria were operationalized as (1) being admitted for at least 2 days (in the week before the assessment) to an inpatient ward (being hospitalized) or (2) having had contact on at least two clinic visits in the last 6 months with health personnel for treatment or follow-up care. At the healthcare centres involved in the study, healthcare professionals identified potential participants based on inclusion criteria. They introduced the possibility of study participation, consistently emphasizing its voluntary and anonymous nature. Those who agreed to participate were provided detailed information and signed informed consent. Subsequently, they completed the survey on-site or within the next 24 hours from their homes through an online platform.

2.2 | Instruments

SCQ (Sinclair, Hack, et al., 2021): The SCQ consists of 15 items with five response options (Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree) assessing patient's degree of agreement with each item.

The original English SCQ was first culturally adapted and translated into Spanish following the guidelines of the International Test Commission (Muñiz et al., 2013), the World Health Organization (WHO, 2019), and Hambleton and Zenisky (2011). The SCQ was first translated from English into Spanish by a professional translator. A panel of five bilingual (English and Spanish) subject matter experts reviewed the translation before it was back-translated into English by an independent professional translator. The primary objective of the forward and back translation was to establish conceptual and cultural congruence rather than simply producing a rote linguistic translation.

TABLE 1 Descriptive statistics of the study variables.

	n	%
Sex		
Woman	211	69.6
Man	88	29.0
Marital status		
With partner	235	77.6
Without partner	64	21.1
Educational level		
Primary	30	9.9
Secondary	65	21.5
College and above	202	66.7
Main diagnosis		
Anxiety	9	3.0
Chiari type I syndrome	7	2.3
Arthritis	4	1.3
Cancer	154	50.8
Depression	8	2.6
Chronic pain	11	3.6
Amyotrophic lateral sclerosis	31	10.2
Infection	11	3.6
Injury/trauma	16	5.3
Other	45	14.9
Purpose of medical appointment		
Treatment	201	66.3
Follow-up	97	32.0
Intake of medication		
No	193	63.7
Yes	91	30.0
Psychological treatment		
No	172	56.8
Yes, in the past	36	11.9
Yes, in the present	95	31.4

Note: Use of medication for anxiety problems, mood, or sleep disorders.

To further ensure the fidelity, clarity, understandability, ease of use, and acceptability of the Spanish version of the SCQ (SCQesp), cognitive interviews were conducted with 15 patients, following the guidelines of the WHO (2019) for evaluating the comprehensibility of an assessment instrument. During the cognitive interviews, participants were administered the instrument and asked to provide their interpretation of what each item was assessing. They were also requested to rephrase the items in their own words to ensure correct comprehension. Participants were further encouraged to report any

unfamiliar words or expressions. Responses were meticulously analyzed by the expert panel, culminating in unanimous agreement on various aspects. According to the INFLESZ scale (Barrio-Cantalejo et al., 2008), the readability index of the SCQ was 72.61, equivalent to a readability level equivalent to primary school textbooks. Finally, the Spanish version of the SCQ was produced, retaining the same 15 items, format, response categories, and scoring of the original SCQ.

To be able to examine the convergent validity of the SCQesp, other variables were measured, such as patient satisfaction, symptom distress, psychological distress (anxiety, depression, and somatization), and unmet needs. The hypothesis was that compassion would correlate positively with patient satisfaction and negatively with symptom distress, psychological distress, and unmet needs. To assess these variables, the following instruments were used:

Picker Patient Experience Questionnaire (PPE-15) (Cleary et al., 1991; Jenkinson, 2002): The PPE-15 is a 15-item patient satisfaction survey adapted to the Spanish population and provides a meaningful picture of patients' healthcare experience (Barrio-Cantalejo et al., 2009; Bertran et al., 2018). Each item is coded for statistical analysis as a dichotomous "problem score," indicating the presence or absence of a problem. A problem is defined as an aspect of health care that could, in the eyes of the patient, be improved upon (Jenkinson, 2002). Thus, higher scores on this scale indicate lower satisfaction with the care experience. In the convergent validity analysis, scores in this scale were expected to correlate positively with those from the SCQesp, meaning lower levels of satisfaction (higher scores) are related to higher levels of compassion. Cronbach's α for this instrument in our sample was 0.844.

Edmonton Symptom Assessment Scale (ESAS) (Bruera et al., 1991): The ESAS is a 10-item measure of patient symptom distress adapted to the Spanish population (Carvajal Valcárcel et al., 2013). Each of the 10 items is rated by patients on an 11-point numeric rating scale ranging from 0 (*no symptoms*) to 10 (*worst possible symptoms*). The sum of the scores for all symptoms is defined as the overall symptom distress score. In the convergent validity analysis, scores in this scale were expected to correlate negatively with those from the SCQesp, meaning lower symptom distress related to higher levels of compassion. Cronbach's α for this instrument in our sample was 0.872.

Brief Symptoms Inventory-18 (BSI-18) (Derogatis, 2001; Spanish version by Derogatis, 2013): BSI-18 is a self-report instrument comprising 18 items rated on a five-point Likert scale that assesses three clinically relevant psychological symptoms (anxiety, depression, and somatization) and provides an indicator for the overall level of psychological distress, which is known as the Global Severity Index (GSI). Furthermore, the BSI-18 includes normative data on cancer populations (Martínez et al., 2019) and allows "caseness" to be identified based on a criterion proposed by Derogatis (2001). "Caseness" refers to whether an individual meets the criteria or threshold for a clinical diagnosis. It indicates whether a person's symptoms or condition are severe enough to be considered a case requiring clinical attention. In the convergent validity analysis, scores

in this scale were expected to correlate negatively with those from the SCQesp, meaning lower psychological distress related to higher levels of compassion. Cronbach's α for this instrument in our sample was 0.925.

Cancer Survivors' Unmet Needs (CaSUN) (Hodgkinson et al., 2007): CaSUN is a 35-item measure designed to assess the presence of unmet care needs in cancer survivors in five domains: comprehensive care and information, physical effects, psychological effects, practical issues, and relationships, which has been adapted to the Spanish population by Martínez et al. (2021; CaSUN-S). For this study, the CaSUN-S was modified to be completed by other patient profiles beyond those of cancer survivors. In the convergent validity analysis, scores in this scale were expected to correlate negatively with those from the SCQesp, meaning fewer unmet needs related to higher levels of compassion. Cronbach's α for this instrument in our sample was 0.958.

2.3 | Data analysis

A CFA was conducted to validate the Spanish version of the questionnaire. In line with previous research (Serrano et al., 2019), the proposal by Hair et al. (1999) was followed to establish cut-off points (acceptable criteria level in parenthesis): root mean square error of approximation (RMSEA) (<0.08; 90% confidence interval [CI]), Nonnormed Fit Index (NNFI) (>0.90), Bollen Incremental Fit Index (>0.90), and Comparative Fit Index (>0.90). Also, the Akaike information criterion and the Satorra–Bentler chi-squared (S–Bχ^2) and this index divided by *df* (S–Bχ^2/df)—to correct the influence of the number of subjects—were also computed. We used the usual maximum likelihood (ML) estimation to ensure comparability with other studies. However, since the type of response of SCQ is a Likert scale, and the multivariate nonnormal distribution of answers of items (normalized Mardia estimate = 63.49), we added a second analysis with heterogeneous kurtosis (HK).

The internal consistency of the SCQesp and SCQesp-SF was explored through Cronbach's α, the composite reliability (CR), and the Stratified Variance Index (SVI). In addition, Cronbach's α was calculated for the other assessment instruments used in the study. The convergent validity of the SCQ was examined through Pearson's correlation analysis and Student's *t*-tests. It was expected that higher levels of compassion would be related to higher levels of patient satisfaction (PICKER scale) and lower levels of symptoms (ESAS), psychological distress (BSI-18), and patients' unmet needs (CaSUN).

Data analysis was performed with SPSS version 26.0 for descriptive analyses and calculation of internal consistency; CFA and average variance extracted were performed using the structural equation modelling software (version 6.3) (Bentler, 2006) and, finally, Microsoft Excel version 16.31 was used for the calculation of the composite variance.

3 | RESULTS

Three hundred and three patients agreed to participate (response rate = 83.9%), provided informed consent, and completed the questionnaires by self-report. Participants took approximately 20 min to complete the protocol, including other questionnaires and the SCQ. The 15-item SCQ took participants approximately 4 min to complete.

The mean age of the participants was 53.45 years old (SD = 13.37). Most of them were women (70.6%), had a partner (78.6%), and had completed higher education (68%) (Table 1). Concerning medical conditions, the two most frequent diagnoses were cancer (52%) and amyotrophic lateral sclerosis (10.5%). The mean time since diagnosis was 32.50 months (SD = 61.81; range: 0–444 months), with 67.4% of participants accessing medical care for treatment (n = 201), compared to 32.6% for follow-up care (n = 97). The mean number of visits was 13.4 times in the last year (SD = 14.03) and 9.1 times in the last 6 months (SD = 19.41). Regarding the number of hospitalizations in the last 6 months, 161 participants reported being hospitalized. The mean number of hospitalizations over the last 6 months was one time (SD = 1.99), with a mean admission of 2 days (SD = 3.79); 39.6% (n = 120) reported receiving home care visits by their healthcare providers over the last 6 months, with a mean of 1.3 visits during this period (SD = 4.49) (see Table 1).

The internal validity of the instrument was explored using CFA. Previously, the adequacy of the data was tested using the Kaiser–Meyer–Olkin (KMO) method and Bartlett's test of sphericity. The KMO test (0.96965; 95% CI = 0.970–0.973) and Bartlett's test of sphericity (3409.7; df = 105; p = 0.000010) showed highly satisfactory coefficients, so the CFA was performed.

Table 2 reports the results of the CFA of the first-order models with a 15-item version (SCQ-S). Model 1A was computed using both HK and ML estimation. Moreover, the five-item version (SCQ-SV-S) is shown (Model 2 with HK estimation). As can be seen in Table 2, Model 1A (HK and ML) showed high error indices, so we improved the estimation by including the correlations between some errors (1–2, 10–11, 12–15) considering the modification indexes. The

improved models (particularly Model 1B HK) showed acceptable error indices (e.g., RMSEA of about 0.80) and excellent adjustment values.

Next, Model 2 was calculated with only items 4, 6, 7, 9, and 14. Model 2 (HK) showed a good fit, and the error values were acceptable, while the fit indexes of Model 2 (ML) were less good.

Figure 1 shows the final version of the CFA of SCQesp (Model 1B, HK estimation) and SCQ-esp-SF (Model 2, HK version). As can be seen, the saturations in both models are high and above 0.70. Both are based on the HK estimator.

Next, Model 2 was calculated with only items 4, 6, 7, 9, and 14. Model 2 (HK) showed a good fit, although the error values were slightly high. While these values were reduced (RMSEA = 0.000) after introducing the correlation between errors (items 7–9), several fit indices increased above 1.00, so this improvement was not finally introduced.

Figure 1 shows the final version of the CFA of Models 1 and 2, both based on the HK estimator. As can be seen, the saturations in both models are high and above 0.70.

The SCQesp showed satisfactory values of reliability: Cronbach's α = 0.98; CR = 0.98 (0.905–0.854); and SVI = 0.78. At the same time, the SCQesp-SF showed satisfactory values of reliability as well: Cronbach's α = 0.95; CR = 0.95 (0.941–0.958); and SVI = 0.78. Also, Cronbach's α was satisfactory for every instrument used.

Descriptive data on the clinical variables of the study and reliability indexes for all instruments are shown in Table 3. As evident, participants reported high levels of compassionate care and were largely satisfied with the care received (with lower scores on the scale indicating higher satisfaction).

Compassion was negatively associated (Table 4) with symptomatology (p ≤ 0.01); emotional distress, both in terms of the total score (GSI) (p ≤ 0.05) and prevalence of clinically significant distress (p ≤ 0.01); satisfaction (p ≤ 0.01) (a lower score on the scale indicating higher satisfaction); and presence of unmet patient support needs both overall and in each of the domains: medical information and care, physical effects, psychological needs, interpersonal relationships, and practical issues (p ≤ 0.01 in all cases).

TABLE 2 Models fit indexes for SCQesp (Model 1A, Model 1B) and SCQesp-SF (Model 2).

Model	S–Bχ²	df	S–B/df	CFI	IFI	NNFI	RMSEA (CI)	AIC
1A (HK)	350.30***	90	3.89	0.98	0.98	0.97	0.098 (0.087–0.109)	170.30
1A (ML)	379.77***	90	4.22	0.93	0.93	0.91	0.098 (0.087–0.108)	169.78
1B (HK)	259.88***	87	2.98	0.98	0.98	0.98	0.081 (0.070–0.092)	85.88
1B (ML)	278.80***	87	3.20	0.95	0.95	0.93	0.085 (0.074–0.097)	104.80
2 (HK)	14.08*	5	2.82	0.99	0.99	0.98	0.078 (0.031–0.127)	4.08
2 (ML)	17.65***	5	3.53	0.99	0.99	0.97	0.092 (0.048–0.139)	7.65

Abbreviations: AIC, Akaike information criterion; CFI, robust comparative fit index; CI, confidence interval; df, degree of freedom; HK, heterogeneous kurtosis; IFI, Incremental Fit Index; ML, maximum likelihood; NNFI, robust Nonnormed Fit Index; RMSEA, root mean square error of approximation (CI); S–Bχ², Satorra–Bentler chi-squared; SCQesp, Spanish version of the Sinclair Compassion Questionnaire; SCQesp-SF, five-item short-form version.

*p < 0.05; ***p < 0.001.
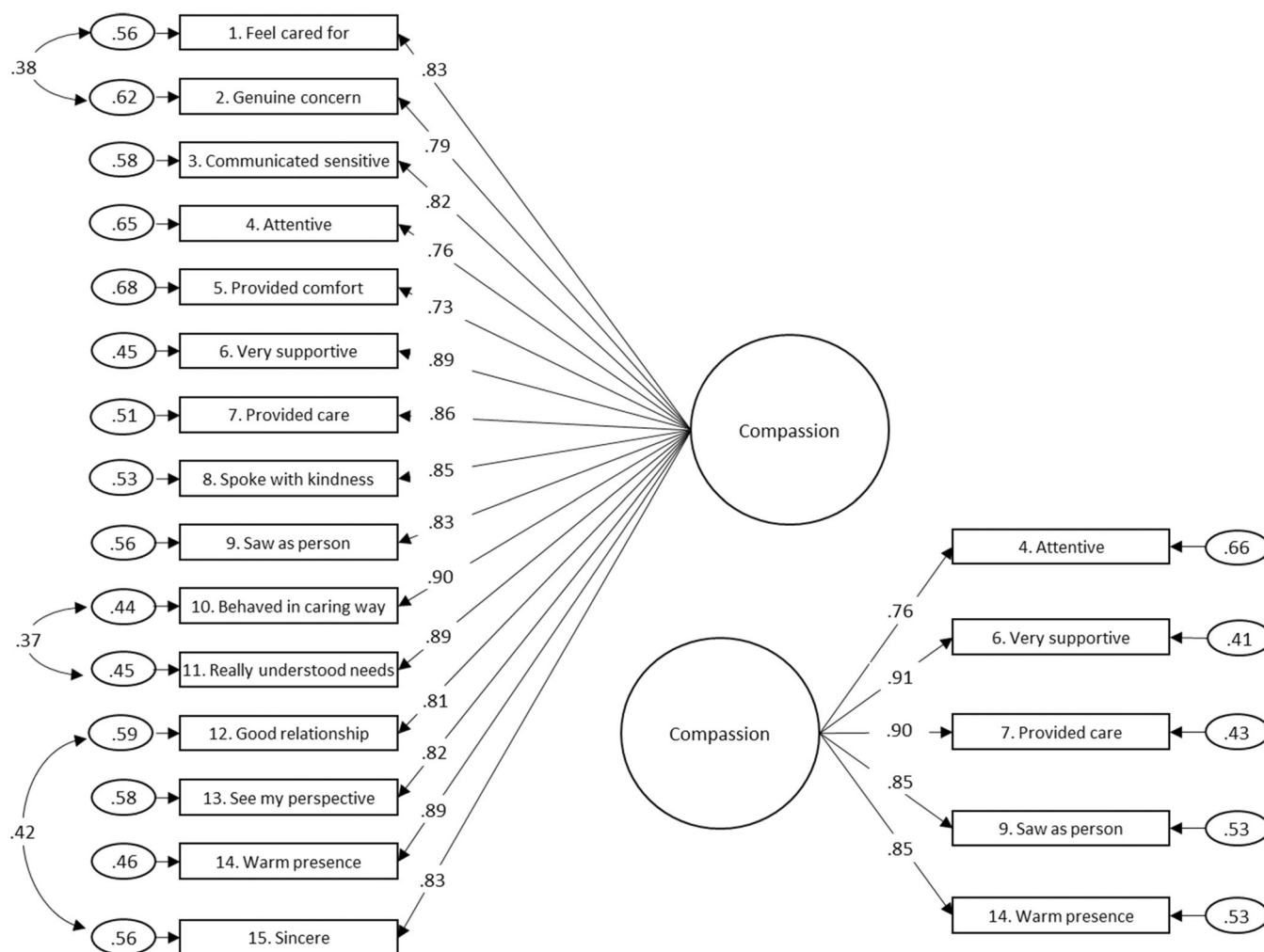
FIGURE 1 Final confirmatory factor analysis model for Spanish version of the Sinclair Compassion Questionnaire (left side) and five-item short-form version (right side).

Additionally, the results regarding the convergent validity (Table 5) of the short version of the SCQesp-SF produced strong results similar to the SCQesp, with the correlation with the latter being 0.98.

4 | DISCUSSION

While compassion is increasingly considered a fundamental dimension of quality of care across cultures (Francis, 2013; Malenfant et al., 2022; Papadopoulos & Ali, 2016; Paterson, 2011; Singh et al., 2018; Sturgeon, 2008; Trzeciak et al., 2017), a valid and reliable Spanish compassion measure did not previously exist (Soto-Rubio et al., 2023). Therefore, the main objective of the present study was to develop and validate the Spanish version of the SCQ (Sinclair, Hack, et al., 2021) to address this gap. The SCQ, which has been extensively validated across diverse English-speaking populations (Boss et al., 2023; Sinclair, Hack, et al., 2021; Sinclair et al., 2018; Singh et al., 2020; Smith-MacDonald et al., 2019), makes three significant contributions to the field of compassion research in healthcare:

(1) it is framed on an empirical model of compassion that was constructed from direct patient accounts (Sinclair et al., 2016), (2) it was developed in accordance to strict measure and development guidelines (Sinclair, Hack, et al., 2021; Sinclair et al., 2018, 2020; Sinclair, Jaggi, Hack, Russell, McClement, Cuthbertson, Selman, et al., 2020), and as a result has been confirmed as the gold standard compassion measure (Sinclair, Hack, et al., 2021; Sinclair et al., 2018; Sinclair, Jaggi, et al., 2020), and (3) it assesses compassion from the perspective of the recipient (patients) in contrast to the provider (healthcare providers), addressing a significant limitation while ensuring a patient-centered approach (Sinclair, Hack, et al., 2021).

An inherent limitation in measure translation research is the failure to validate the measure, both culturally and linguistically, within the actual population of interest in contrast to simply translating. In this study, we adhered to rigorous measure adaption guidelines to ensure that Spanish understandings of the construct of compassion and associated items were culturally appropriate and meaningful.

The results of the CFA were excellent, obtaining fit indices that confirm that the Spanish version of the SCQ has a unifactorial

TABLE 3 Descriptive statistics of the study variables.

	$\bar{x}$	SD	Range	Cronbach's α
Experience of compassion (SCQesp)	62.86	13.05	15–75	0.98
Experience of compassion-short form (SCQesp-SF)	21.07	4.31	5–25	0.95
Symptomatology	31.52	20.16	0–100	0.87
Emotional distress				
Somatization	4.85	4.44	0–72	0.79
Depression	4.73	4.93	0–72	0.86
Anxiety	4.75	4.78	0–72	0.86
Global distress	14.33	12.56	0–72	0.93
Clinical caseness, $n = 59$ (19.6%)				
Satisfaction	5.85	3.87	0–15	0.84
Unmet support needs	8.92	8.46	0–35	0.96
Information and attention	4.24	0.99	0–3	0.92
Physical	0.77	0.64	0–3	0.81
Psychological	2.33	0.70	0-3	0.94
Interpersonal	0.79	0.60	0–3	0.88
Practical	1.01	0.76	0–3	0.86

Abbreviations: SCQesp, Spanish version of the Sinclair Compassion Questionnaire; SCQesp-SF, five-item short-form version.

structure, coinciding with that of the results of the original English version of the instrument. Likewise, the internal consistency analysis yielded high-reliability indices for the indicators used: Cronbach's α, CR, and SV. The SCQesp is, therefore, a highly valid and reliable compassion measure that allows researchers, system leaders, educators, and healthcare providers to robustly assess and address Spanish-speaking patients' experiences of compassion within healthcare. Consistent with previous research findings (Crowther et al., 2013; Flocke et al., 2002; Francis, 2013; Heyland, 2006; Levinson, 1997; Lown et al., 2011; McDonagh et al., 2004; Murphy et al., 2009; Neumann et al., 2011; Riggs et al., 2014; Sturgeon, 2008; Willis, 2015; Youngsen, 2014), including previous findings associated with the SCQ specifically (Sinclair, Hack, et al., 2021), patients' perception of compassion was significantly associated with better symptom control, lower levels of psychological distress (anxiety, depression, somatization, global index, and caseness distress), higher satisfaction with the healthcare services received, and lower unmet support needs-particularly information and care needs. Therefore, these results not only support the convergent validity of the SCQesp but confirm previous results on compassion's significant impact within English-speaking populations. Compassion, as measured by the SCQ, is a significant driver of the overall patient experience, quality care ratings and various patient outcomes within Spanish patient populations, supporting recent discussions that compassion should be considered as a key performance indicator within

healthcare organizations around the globe (Consedine & Pavlova, 2023; Malenfant et al., 2022; Pavlova et al., 2023; Trzeciak & Mazzarelli, 2019).

The excellent psychometric results obtained by the SCQesp were replicated in a secondary analysis of the SCQesp-SF. Congruent with previous findings obtained by Sinclair, Hack et al. (2021) with a sample size of 303 patients, the 5-item version of the SCQesp showed excellent structural validity and internal consistency results. In addition, its high correlation with the SCQesp and the replication of the relationships found between this instrument and the rest of the variables considered make the short version of the SCQesp-SF an excellent option to assess compassion received in the healthcare setting, where brevity is of chief importance.

Interestingly, a correlation was identified between compassion scores and the absence of a partner and older age. This finding may be attributed to individuals without a partner expressing a higher appreciation for compassionate care, as they lack the support typically provided by a partner. Simultaneously, older individuals may perceive themselves as more vulnerable, leading to a heightened value placed on compassionate care. Nonetheless, it is essential to note that the data of the current study do not permit conclusive statements in this regard. Further research is warranted to explore these relationships more thoroughly.

The present study is not without limitations. First, the absence of previous measures of compassionate care precluded a more direct test of the convergent validity of the SCQesp. Although the study was carried out on a diagnostic heterogeneous sample of similar size ($N = 303$) to that used in the original validation of the instrument (Sinclair, Hack, et al., 2021), it was not large enough to explore the possible moderating role of relevant variables such as the stage of illness or type of diagnosis. Future research should address these issues in larger samples, with other diagnoses and healthcare settings. While acknowledging the minimized impact of memory bias due to the prompt response within 24 h of the last contact with healthcare personnel, it is crucial to recognize other limitations associated with self-reported measures. These may include potential issues such as response biases, social desirability, and subjective interpretations that could affect the overall reliability and validity of the collected data. Likewise, because compassion is inherently relational, it would be interesting to assess compassion from the healthcare provider's point of view.

In conclusion, the main contribution of this study was the development and validation, for the first time, of a valid and reliable Spanish compassion measure. The SCQesp and the SCQesp-SF are culturally appropriate, strongly reliable, and highly valid patient-reported measures of compassion. The SCQesp allows researchers to study associations between compassion and other variables within Spanish healthcare settings while facilitating international studies comparing and contrasting patients' experiences of compassion across cultures. The SCQesp also provides healthcare providers with a standardized measure to assess their patients' experiences of compassion on a routine basis while providing governments, organizational leaders, and system analysts the ability to identify

TABLE 4 Relational analysis between compassionate care (SCQesp) and the rest of the study variables.

	Compassionate care			
		t-Test/ANOVA		
	r^2	$\bar{x}$ (SD)	t/F	Significance
Sociodemographic and disease-related variables				
Age	0.19**			0.00
Sex				
Woman		62.69 (13.25)	−0.36	0.72
Man		63.30 (12.71)		
Marital status				
With partner		61.82 (13.70)	−3.266	0.00
Without partner		66.72 (9.64)		
Educational level				
Primary		66.23 (11.74)	2.25	0.11
Secondary		64.65 (12.91)		
College and above		61.83 (13.27)		
Intake of medication				
No		62.24 (11.67)	0.39	0.53
Yes		62.24 (14.53)		
Psychological treatment				
No		62.32 (14.53)	0.91	0.40
Yes, in the past		61.58 (9.66)		
Yes, in the present		64.32 (15.06)		
Time since diagnosis	0.00			0.17
Purpose of medical appointment				
Treatment		63.53	0.74	0.46
Follow-up		62.25		
Hospital stays in the previous 6 months	0.06			0.09
Length of hospital stays	0.07			0.57
Remaining study variables				
Symptomatology	−0.24**			0.00
Emotional distress	−0.37**			0.00
No clinical caseness		64.60 (11.189)	3.662	0.00
Yes clinical caseness		55.98 (17.197)		
Somatization	−0.27**			0.00
Depression	−0.29**			0.00
Anxiety	−0.42**			0.00
Satisfaction	−0.74**			0.00
Unmet support needs	−0.33**			0.00
Information and attention	−0.33**			0.00
Physical	−0.24**			0.00

TABLE 4 (Continued)

	Compassionate care			
	r^2	t-Test/ANOVA		
		x̄ (SD)	t/F	Significance
Psychological	−0.19**			0.00
Interpersonal	0.27**			0.00
Practical	−0.27**			0.00

Abbreviations: ANOVA, analysis of variance; SCQesp, Spanish version of the Sinclair Compassion Questionnaire.
**$p < 0.01$.

TABLE 5 Relational analysis between SCQesp-SF and the rest of the study variables.

	Compassionate care—short			
	r^2	t-Test/ANOVA		
		x̄ (SD)	t/F	Significance
Sociodemographic and disease-related variables				
Age	0.19**			0.00
Sex				
Woman		21.03 (4.28)	0.063	0.803
Man		21.17 (4.43)		
Marital status				
With partner		20.73 (4.48)	7.015	0.009
Without partner		22.33 (3.40)		
Educational level				
Primary		22.37 (3.07)	2.619	0.075
Secondary		21.63 (4.22)		
College and above		20.71 (4.47)		
Intake of medication				
No		21.01 (4.61)	0.021	0.886
Yes		21.09 (4.03)		
Psychological treatment				
No		20.76 (4.28)	1.383	0.252
Yes, in the past		20.97 (3.19)		
Yes, in the present		21.67 (4.31)		
Time since diagnosis	0.034			0.17
Purpose of medical appointment				

TABLE 5 (Continued)

	Compassionate care—short			
	r^2	t-Test/ANOVA		
		x̄ (SD)	t/F	Significance
Treatment		21.30 (3.97)	0.742	0.390
Follow-up		20.85 (4.93)		
Hospital stays in the previous 6 months	0.058			0.09
Length of hospital stays	0.071			0.57
Compassionate care	0.98**			
Remaining study variables				
Symptomatology	−0.23**			0.00
Emotional distress	−0.34**			0.00
No clinical caseness		21.62 (3.79)	20.91	0.001
Yes clinical caseness		18.85 (5.49)		
Somatization	−0.24**			0.00
Depression	−0.26**			0.00
Anxiety	−0.40**			0.00
Satisfaction	−0.73**			0.00
Unmet support needs	−0.30**			0.00
Information and attention	−0.33**			0.00
Physical	−0.22**			0.00
Psychological	−0.16**			0.00
Interpersonal	−0.25**			0.00
Practical	−0.22**			0.00

Abbreviations: ANOVA, analysis of variance; SCQesp-SF, Spanish version of the Sinclair Compassion Questionnaire five-item short-form version.
**$p < 0.01$.

benchmarks, measure, and report compassion scores at a unit, institution, and regional level.

Spanish versions of the SCQ, along with English, French, and Mandarin versions, instruction manuals, data management resources, and instructional videos on administering, scoring, and interpreting the SCQ are available from the authors or at https://www.compassionmeasure.com.

5 | CONCLUSION

The results of the present investigation demonstrate the excellent psychometric properties of the SCQesp and the SCQesp-SF, establishing them as useful and valid tools for assessing the compassion perceived by patients in the healthcare setting and the role that compassion plays in the quality care ratings of Spanish patients.

AUTHOR CONTRIBUTIONS

All authors contributed to the study's conception and design. The selection of the keywords and the initial searches were carried out among all the researchers. The final searches, screening, and elaboration of the collection protocol were carried out by Yolanda Andreu-Vaillo and Ana Soto-Rubio. The first draft of the manuscript was written by Ana Soto-Rubio. The following versions were reviewed by Yolanda Andreu-Vaillo and Shane Sinclair, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

This study was complied with the principles of the Declaration of Helsinki.

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