

Implementing dialogic communication for complaint management in Malang Private Hospital, Indonesia

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Abstract Persistent increases in patient complaints in private hospitals indicate a structural gap in how complaint management systems integrate dialogic communication principles in practice. This mixed-method study examined the implementation of a dialogic communication framework in managing patient complaints at a private hospital in Malang, Indonesia. This study particularly focused on how the current complaint system reflects the principles of mutuality, transparency, and organisational commitment. This study integrated in-depth interviews with key stakeholders and a quantitative analysis of 605 patient complaints. The findings indicate a fractured dialogue that demonstrates a substantial gap between the procedurally and performatively responsive complaint system and its actual capacity for genuine dialogic communication. This management misconduct is rooted in systemic fragmentation, sectoral ego, and an organisational unwillingness to embrace the risk of transparency. Ultimately, this study proposes the Integrated Public Service Communication Flow model, designed to shift the organisational culture from a reactive and monologic approach to a proactive, relational, and genuinely dialogic. This proposed model accentuates a concrete framework for rebuilding patient trust by embedding mutuality and commitment into the hospital operations.

Keywords: complaint management; dialogic communication; hospital management; public service

INTRODUCTION

The quality of communication between healthcare providers and patients is a critical determinant that influences the overall patient experience. In hospital settings, staff-patient interactions frequently happen in highly emotional and clinically intricate scenarios, generating effective communication crucial for fostering satisfaction and trust (Davenport, 2022; Shisundi, 2023). Dialogic communication model (Kent & Taylor, 2021), highlighting reciprocity, transparency, and mutual respect, has drawn significant attention as a transformational paradigm in service delivery (Kent, 2023; Nartey et al., 2023). The Dialogic Communication framework underscores mutuality, openness, and a commitment to fostering enduring relationships via ongoing reciprocal interaction. In this study's setting, these principles are particularly pertinent as effective complaint management in private hospitals necessitates more than mere procedural resolution; it involves authentic involvement that acknowledges patient concerns and cultivates trust. In contrast to transactional models that regard communication as a unilateral exchange of information, dialogic communication approaches recognize patients as active participants whose viewpoints are considered essential to decision-making processes (Yamada, 2025).

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The healthcare sector acknowledges that patient complaints should not merely be viewed as indicators of dissatisfaction but as strategic opportunities for enhancing service quality (Aboalghanam et al., 2024; Omari et al., 2023). An effective management of the complaints, specifically when drawn into dialogic principles can transform negative feedback into a productive interaction which can strengthen the hospital-patient relationship (Kim et al., 2024; Yamada, 2025). Nonetheless, this study found a knowledge gap regarding the implementation of dialogic framework in research within private hospitals in Southeast Asia, particularly in Indonesia (Gerken et al., 2025; Güllüpinar, 2023; Nyambo, 2024).

Practically, private hospitals in Indonesia tend to advertise themselves as providers of superior services, equipped with modern facilities and meticulous care (Widarna et al., 2024). However, several private hospitals were challenged to employ dialogic complaint management practices which led to the minimal involvement in the resolution process (Lloyd et al., 2023; Omari et al., 2023).

Hence, this form of complaint management fails to promote transparency or collaboration which are important to establish sustainable trust in healthcare communication. Hence, patients frequently experience uncertainty in the status of their complaints or the reasoning for the hospital's responses, which decreases the opportunity to improve the dialogic communication practice (Havana et al., 2023).

Several empirical studies in Indonesia demonstrate that communication plays a key role in shaping the effectiveness of complaint management in hospital settings. A qualitative study in the Indonesian hospital management context highlights structural challenges in complaint management, including fragmented reporting systems, limited professional communication competence, and lack of coordination between administrative and clinical units, which ultimately constrained service recovery efforts (Khairunnisa et al., 2023). Adriansyah et al. (2023) also conducted study at an Islamic private hospital in Surabaya, East Java by analysing 261 patient complaints in a single year. The study highlights that the majority of the 261 complaints are related to medical services, particularly inpatient care, where root causes included miscommunication, limited human resources, inadequate empathy, and weak coordination across the departments. In relation to the other studies, a quantitative study by Supriatin et al. (2022) with a case study in Tangerang city indicates that the therapeutic communication performed by the nurse significantly influences the outcomes of complaint handling, patient satisfaction, and patient loyalty, accentuating the strategic role of interpersonal communication in maintaining service quality within the hospital. These empirical studies conclude that at the normative level, Indonesian healthcare management in hospitals reinforces the importance of dialogic communication, positioning transparency and participatory interaction as fundamental factors in medical services.

Additionally, several studies in the sector of public healthcare indicates that communication significantly improves service recovery, especially in situations filled with frequent and complex complaints (Güllüpinar, 2023; Venuleo et al., 2024). However, these studies are mainly focused on general hospitals and cannot be simply generally applied to private hospital environments without considering the varying level of patient demographics, service expectations, and operational challenges. For instance, in Indonesia, private hospitals tend to cater to a broad socio-economic patient demography which presents a distinct challenge in harmonising communication approaches with different levels of literacy about health as well as cultural norms (Sembiring et al., 2024; Thamrin et al., 2025). Hence, these kinds of diversity can hinder the implementation of dialogic communication unless the model is altered to the local context of each hospital.

Moreover, the Standard Operation Procedures (SOP) of numerous private hospitals are predominantly filled with compliance-oriented yet generalised regulations (Babenko, 2021). These SOPs mainly emphasise compliance with regulatory standards rather than promoting hospital-patient engagement, which can restrict the level of dialogic communication. Consequently, this lack of flexibility decreases the capacity of the hospital to source insights from complaints that facilitate systemic improvement. Hence, the existing research gap pertains to the development of evidence-based integration of dialogic communication models to manage complaints in private hospitals in Indonesia.

In Malang, East Java, the expansion of private hospitals has intensified competition in service quality, patient satisfaction, and institutional reputation. As a prominent educational and referral city, Malang hosts multiple private healthcare institutions that actively promote modern facilities and patient-centred care as strategic differentiators. This study contends that addressing this gap is important for multiple reasons which surpass mere theoretical contribution. Several studies highlight a correlation between patient satisfaction, loyalty, and the perceived efficacy of complaint handling systems (Chen et al., 2024; Nguyen et al., 2021). Moreover, private hospitals are naturally working in a competitive market where service differentiation can significantly impact patient preference. Thus, this study argues that adopting strategies based on a dialogic communication model can provide a competitive edge by creating both responsive and relationship-driven hospital environments.

This study aims to examine the complaint management strategy of a leading private hospital in Malang, East Java, Indonesia through the Dialogic Communication framework (Kent & Taylor, 2021). The selection of this one particular private hospital is significant because it represents one of the most prominent and fully accredited type B private hospitals in Malang, equipped with comprehensive facilities and advanced medical technology, including tertiary level inpatient and intensive care services. Furthermore, the hospital has been officially recognised as meeting international operational standards and was designated as a referral hospital by the United States Army during joint military activities in Malang, indicating its institutional credibility and high service expectations. However, the preliminary research in the hospital through document study indicates that the high number of complaints are related to infrastructure, waiting times, and clarity of information. The findings demonstrate that the primary challenges that the hospital face are not purely technical but also reflect weaknesses in maintaining strategic communication with patients. Ultimately, this pattern of complaints demonstrates the need to shift towards a dialogic communication model which enables reciprocal interaction and direct clarification.

The main objective is to rigorously evaluate the current complaint handling approaches to identify situations where communication is restricted to transactional interactions. This study also aims to identify challenges that hinder the adoption of dialogic concepts, encompassing organisational, cultural, and technological limitations. The final objective is to develop a context-specific dialogic communication model that can be conveniently integrated into the hospital's operational framework. Ultimately, this research aims to provide strategic recommendations that will inform policy modifications, personnel training, and technical advancements to maintain dialogic practices over time. Hence, this study proposed a research question: How is dialogic communication implemented in managing patient complaints at a private hospital in Malang, East Java, and to what extent does the existing complaint management system reflect the principles of mutuality, transparency, and organisational commitment?

METHODOLOGY

To examine the integration of dialogic communication in managing patient complaints, this study employs a mixed-methods case study design with a particular focus on a private hospital in Malang, East Java. Malang was selected as the research focus because the city serves as a major urban centre with a relatively concentrated health service infrastructure, including a range of public and private hospitals that cater to multiple ranges of patient demography and complex service demands (Pratiwi et al., 2025). According to official records, the city of Malang has numerous general and private hospitals, such as RSUD Dr. Saiful Anwar, Panti Nirmala Hospital, Lavalette Hospital, Persada Hospital, and several others that collectively serve as primary healthcare providers for the municipal and surrounding regional population (Pemerintah Kota Malang, 2026). The selected hospital for this case study is one of the largest private general hospitals in Malang, classified as Type B and equipped with comprehensive clinical services. The private hospital was purposely chosen based on its institutional prominence, volume of patient interactions, and documented complaints data, providing an extensive empirical data to investigate how dialogic communication principles are operationalised within a competitive private healthcare environment.

A mixed-method case study methodology was employed due to its ability to conduct a thorough examination of intricate social conditions within their genuine contexts, allowing this study to gain data regarding both procedural metrics and relational aspects of healthcare

communication (Poth, 2023). The quantitative component of this mixed methods case study consisted of document analysis of 605 patient complaint records obtained from the internal complaint management system of a private hospital in Malang. The obtained dataset includes complaints submitted between November 2023 and July 2024 through officially recognised reporting channels, including customer service submissions, written feedback forms, suggestion boxes, digital platforms, and direct reports recorded by hospitals. After institutional approval was granted, this study analysed the archived database and conducted a screening process to exclude duplicate or incomplete entries, resulting in 605 validated complaint documents. These records provided measurable indicators of recurring service-related challenges, which were subsequently categorised and quantified to identify dominant patterns in complaint types.

The qualitative component consisted of semi-structured interviews with hospital executives and frontline personnel directly involved in complaint management, as presented in Table 1. The interviews explored organisational policies, communication flows, operational constraints, and relational dynamics underlying complaint handling practices. By integrating documentary evidence with experiential and managerial perspectives, this triangulation strategy strengthened the analytical validity of the study and ensured that interpretations were not derived from a single data source (Kawar et al., 2024).

Table 1. Key informants mapping

Informant code	Position/role	Relevance to complaint management	Interview date
INF-01	Vice Director	Strategic oversight; policy approval; Root Cause Analysis supervision	3 March 2025
INF-02	Supervisor of Public Relations	Complaint intake, coordination, and external communication	3 March 2025
INF-03	Manager of General Affairs and Digitalisation	Infrastructure response; digital system management	3 March 2025
INF-04	Manager of Medical Support	Waiting time management; operational adjustments	3 March 2025
INF-05	Nursing Manager	Patient communication at point of care; information clarification	3 March 2025

Source: Primary data from in-depth interviews, 2025

The quantitative data regarding patient complaint records obtained from the hospital's internal data were analysed with thematic findings gained from the interview to construct a comprehensive analysis of the existing communication strategies conducted by the hospital. Data reduction process was conducted by a systematic screening and categorisation process. For the quantitative findings, duplicate and incomplete entries from the dataset were excluded, and each validated complaint was coded into thematic categories based on the dialogic communication framework as the main focus of this study. Furthermore, frequency tabulation and calculations of percentage were conducted in order to identify dominant complaint patterns. On the other hand, the qualitative data were analysed by employing a hybrid coding approach, integrating deductive codes based on the dialogic communication framework with inductive codes built by the data. The deductive codes ensured the analysis complied to academic principles including mutuality and responsiveness, and the inductive method aimed to uphold the validity of the emerging themes (Flake et al., 2022).

To ensure reliability, the coding framework was applied consistently across all data and subjected to repeated cross-checking in the data analysis process. This mixed-methods approach represents critical practices in healthcare communication studies, since the combination of qualitative and quantitative insights yields more robust evidence for both scholarly and practical applications. Hence, this study involved several coding cycles and peer debriefing processes to optimise the academic standards and decrease interpretative bias.

RESULTS AND DISCUSSION

This section presents and critically discusses the findings related to the implementation of dialogic communication at a leading private hospital in Malang, Indonesia, drawing from both quantitative complaint data and qualitative interviews with the management team. The results and discussion section are organised into three primary themes, starting with an analysis of communication surrounding tangible infrastructure complaints. The second theme discusses

process failures related to waiting times and how the hospital management can provide information clarity. Lastly, the last theme synthesizes these challenges to propose a strategic framework to strengthen dialogic engagement which aims to improve hospital-patient relations.

Firstly, the analysis of 605 patient complaints documented from November 2023 to July 2024 in the private hospital indicates that dissatisfaction is mainly focused on three key areas: infrastructure (31.4%), waiting times (20.5%), and clarity of information (18.7%). Complaints regarding infrastructure received the highest number, with patients frequently mentioning insufficient seats in waiting areas, inadequate parking facilities, and maintenance issues with medical equipment. Furthermore, complaints about waiting times mostly related to delays in outpatient services and processes, whereas complaints regarding information clarity included misunderstanding over treatment directives, ambiguous scheduling, and inadequate disclosure of prescription usage. Collectively, these three categories constituted over 70 percent of total complaints, showing that service dissatisfaction arises from both specific operational issues and abstract communication deficiencies.

The dialogue over tangibles: deconstructing infrastructure complaints as a communication process

Firstly, complaints regarding the private hospital's environment which are typically classified into facility management, indicate more than simple operational feedback; they serve as an important and concrete form of communication between the patient and the hospital. When a patient reports a defect in air conditioner, unreliable wi-fi connection, or unsanitary facilities, they regard them as an issue which can decrease their level of comfort, safety, and a conducive healing environment, rather than just technical issues. Hence, those problems turned to initiate a dialogic exchange between the patients and the hospital. Data from a private hospital in Malang, Indonesia, from November 2023 to July 2024, indicates that infrastructure-related complaints were the most prevalent, totalling 190 reports and comprising 31.4% of all complaints. This substantial number of complaints emphasises that the physical environment becomes a crucial locus where the patients' experience and the responsiveness meet. A comprehensive analysis of these complaints, however, reveals a distinctive conflict between the hospital's advanced communication management system and the quality of their operational system. Hence, this phenomenon highlights a discussion that tends to procedurally react yet fundamentally unresolved.

To address these problems, the hospital has developed a system to facilitate dialogue, which can be related to the principles of effective public relations and dialogic communication theory. Firstly, the Public Relations (PR) Supervisor (INF-02) stated the structure of the complaint management process, which demonstrates their dedication to procedural justice below:

"The patient complaint process begins with the patient conveying the complaint... If the patient is not satisfied with the initial response, the complaint is coordinated with PR for further investigation, classification, and escalation to the fitting unit... This entire process is documented, and the target response time is 1x24 hours, with follow-up actions scheduled based on the severity grading of the complaint." (Supervisor of Public Relations (INF-02), in-depth interview, 3 March 2025).

The findings above indicate a structured workflow, featuring numerous channels and time-sensitive objectives, which are related to a purposeful application of the dialogic principle. The 24-hour response period indicates immediacy, and the formal documentation and escalation procedure indicates mutuality by recognising the patient's complaint as an important input for the management. This study contends that this procedural responsiveness is paramount, as several studies demonstrate that timely acknowledgement contributes to the decreasing level of initial dissatisfaction (Burke & Leben, 2024; Subramaniam et al., 2024). However, a comprehensive examination needs to be done to examine whether this procedural efficiency contributes to a dialogic communication between the hospital management and the patients. This study reveals that the system proficiently creates a hospital-patient discussion; yet its capacity to maintain the discussion to become a meaningful resolution is obstructed by established structural problems.

Furthermore, the core paradox emerges when comparing the improved communicative interface conducted by the PR department with the clear practical reality expressed by the

Manager of General Affairs and Digitalisation (INF-03). This department, mandated with performing physical repairs, functions under a unique set of challenges that tend to be unseen by the patient.

"From the maintenance side, the most challenging part is the building's quality, which is no longer in its best condition having undergone numerous repairs... Moreover, infrastructure repairs are costly, require meticulous planning, and the hospital's management has its own budget allocation and agendas. One of the most prominent complaints from the patients is the central AC system, which can decrease their comfort in the hospital. The repair budget is high, and it takes a lot of consideration for the management to approve." (Manager of General Affairs and Digitalisation (INF-03), in-depth interview, 3 March 2025).

The findings above present a fundamental problem in their practical dialogic communication framework internally. Despite the fact that the hospital tries to uphold a sense of responsiveness, the implementation remains as a challenge. The cyclical complaints regarding the air conditioning system exemplify the issue. Based on their Key Performance Indicator (KPI), a complaint must be handled within 24 hours. Yet, the hospital sometimes can't solve the complaints directly. This study contends that this problem indicates a scenario of superficial dialogism, wherein the mode of communication (a prompt response) exists, while the essence (a resolution) fails to be performed. This phenomenon fundamentally weakens the dialogic promise within their commitment, which necessitates authentic as well as long-term efforts to address public concern (Borson et al., 2023; Kent & Taylor, 2021). In light of these findings, several studies also highlight that when patients persistently encounter the same unresolved issue, the conversation shifts from being transformative to merely performative, which results in a gradual loss of the initial trust built by a prompt response that fosters a sense of institutional insincerity (Bodonhelyi et al., 2025; Kooijman & Canfield, 2024).

In response to the cycle of unresolved challenge; nonetheless, the suggested solutions reflect the hospital's inward-analysis, procedural methodology. The Vice Director (INF-01) demonstrates persistent complaints as an indication that requires a formal, methodical inquiry instead of an instant and transparent discussion, as stated below:

"The on-going and recurring complaints demonstrate the root cause has not been fully addressed. We conduct our own assessment through trend analysis of complaints using the RCA (Root Cause Analysis) method and implementing follow-up procedures as regulated in the RCA." (Vice Director (INF-01), in-depth interview, 3 March 2025).

Based on the findings above, the implementation of Root Cause Analysis (RCA) is a standard quality improvement effort, which its application highlights the internal orientation of the hospital's problem-solving cycle. The process is designed to discover and fix an internal failure, but this study argues that it fails to inherently include the patient in that extended dialogue. The patients who send complaints are not typically part of the RCA process, nor are they necessarily informed of its finding or the long-term corrective strategies that are planned. This phenomenon reinforces an asymmetry in information where the hospital maintains control over the narrative of the problem and its solution. Furthermore, this finding further distancing the process from a truly mutual and co-creational dialogue within the hospital management.

Furthermore, the internal logic in handling these complaints exemplify an imbalance in power which challenges the very notion of a two-way dialogue. Unfortunately, the Manager of General Affairs admits that the complaint prioritization is still subjective. This unclear decision-making process, driven by budget and operational convenience, is not communicated to the patient, which has become a general knowledge in society. Even though the patients are welcomed to speak, they are not aware of the rules governing how their opinions will be valued or processed. This finding is a departure from a truly dialogic ethic, which involves risk and a willingness to cede some authority to control the other parties (Mahlangu, 2024; Nartey et al., 2023). This study argues that by withholding the reasons for delays or being not dialogically solute, the hospital merely maintains its institutional authority and reduces the patient to a passive receiver of its decisions, rather than an equal partner in the dialog.

Based on the findings in this sub-section, this study proposes that this organisational self-talk phenomenon, exemplified by the Vice Director's reliance on the Root Cause Analysis (RCA)

demonstrates an internal management failure. The hospital's problem-solving protocols are designed and implemented to talk about the patient, not to talk with them. This study contends that by excluding the patients from the RCA process, the institution reduces them to a mere data point. This inward-facing and bureaucratic process prioritises finding and fixing an internal failure, rather than relational work of solution co-building. This is not a dialogue in any sense, but it is merely an internal audit triggered by an external factor which reinforces the very sectoral ego and information silos in the managerial level.

This study also argues that the institutional behaviour can lead to direct and negative consequences on the patients, which shifts the burden of labour back onto them. Then the 24-hours procedural acknowledgement does not result in tangible resolution, the patients are somehow forced to become a 'repeat complainer'. The patients must invest more of their own time and emotional energy in navigating the unclear bureaucracy of the hospital. Moreover, the subjective prioritisation admitted by the General Affairs Manager exemplifies that the patients must, in effect, prove their complaints are more worthy than another's. This is a negative experience that keeps undermining the very conducive healing environment the patients were complaining about in the first place.

In conclusion, the hospital's critical failure is not merely its infrastructure management or its limited budget; it is its failure in strategically solving the complaints in a dialogic manner. This study proposes that the hospital is presented with a clear choice: either risk transparency by dialogically proving to the patients or perform responsive strategies with a 24-hours non-resolution. By opting for the latter, the hospital demonstrates the fear and risk of authentic dialogue more that it favours the commitment to a long-term hospital-patient relationship. This strategic option to manage perception rather than reality is the core source of their fractured dialogue, identified in this study.

Fractured dialogue: analysing service process failures in waiting times in relation to information clarity

Beyond the tangible aspects of the hospital environment, this study reveals that procedural elements of the patient journey, especially in waiting times in relation to information clarity, raises as an important spot where the hospital-patient dialogic relationship is most frequently put into a test and fractured. The quantitative data indicate that complaints regarding waiting times (124 complaints, 20.5%), and a lack of information clarity (113 complaints, 18.7%) represent the second and third largest portion of patient dissatisfaction. This finding echoes other studies which state that these complaints are not merely operational failures; they are symptomatic of a system failure in communication management (Feldman et al., 2022; Filip et al., 2022; Gartner et al., 2022). In relation to the findings, this study argues that these procedural failures constitute a fractured dialogue, where the communication process becomes disjointed, one-way, and fails to empower the patient. As a result, these failures in communication can lead to the eroding process of trust and undermine the perceived quality of care.

Furthermore, the experience of a long waiting time is, in itself, a communicative act. This study argues that prolonged and unexplained delays convey a message of disrespect for the patient's time as well as a lack of transparency within the hospital's management. The quantitative data shows that the pharmacy service was identified as the primary sector of this managerial failure, accounting for a significant portion of 124 complaints regarding waiting times. The qualitative data, on the other hand, reveals that the hospital's management is aware of this and has implemented several operational strategies to resolve the issue, as explained by The Manager of Medical support (INF-04):

"We use data from the pharmacy division, specifically in patients' satisfaction surveys and complaints. We also identify issue areas based on the service flow of the prescription process. We have made several adjustments such as changing the queuing system through display, estimating staff requirements, changing shift compositions for high-volume days and hours, moving workers from other pharmacy depots for urgent scenarios, and also upgrading the layout and label of our medicine." (Manager of Medical Support (INF-04), in-depth interview, 3 March 2025).

The findings above reveal that the changes that the hospital has made, such as the implementation of queue display screens, are pragmatic operational measures implemented to

enhance the operational side of the hospital. However, the hospital tends to focus on the mechanics of the procedure rather than the quality of the hospital-patient dialogue. A display screen, for example, serves as a medium for one-way communication processes. It serves its function to notify the patients of their queue status but does not facilitate a dialogue regarding the reasons for the delay or provide an opportunity for the patients to explain their concerns or uncertainties to the hospital during their waiting time. This strategy risks perceiving the patient as a passive entity that can be controlled within a system, rather than as a hospital-patient dialogic partner whose concerns and uncertainties actually need a compassionate involvement (Andersen, 2023; Colgan et al., 2024). Even though minimising waiting time is crucial, lacking in proactive and sympathetic communication during the waiting time can leave the patients feeling helpless and ignorant, which in return can damage the dialogue quality and relationship despite the eventual achievement of the operational strategies (El-Adly et al., 2024; Werder, 2024).

The operational failure is further intensified by significant deficiencies in information clarity, demonstrating a more direct failure of a dialogic hospital-patient communication. The quantitative data shows that there are 113 complaints regarding inconsistent doctor schedules and ambiguous processes. The data indicates a system filled with fragmented information and uneven communication. In light of this finding, the Supervisor of Public Relations (INF-02) directly recognises this systemic challenge:

"One of our biggest communication challenges is information inconsistency. For example, nurse A and doctor B can give different explanations to the same patient...The message is confusing due to the lack of internal coordination...However, the patients are not sure where to ask or even complain." (Supervisor of Public Relations (INF-02), in-depth interview, March 3, 2025).

The absence of internal coordination, as explained by the Supervisor of Public Relations above, places the responsibility of problem-solving entirely on the patients, who must reconcile opposing messages even during their vulnerable state. In relation to these findings, Borson et al. (2023) argue that this certain phenomenon is lacking a singular and reliable source of information which can lead to the decline of dialogue quality. George et al. (2024) also state that this issue is not merely a consequence of error in the frontline but is fundamentally related to the organisational structure in information accountability. Furthermore, the Manager of General Affairs and Digitalisation (INF-03) explains how their department is responsible in managing critics regarding the online doctor scheduling system:

"For the doctor's scheduling, the IT team actually cannot guarantee the accuracy of the information because the timetable is keep changing. So, the IT team tries to create a unique solution for the Marketing and Communications department to update the doctor's schedule by themselves. Actually, that solution can be used to update beyond the doctor's schedule." (Manager of General Affairs and Digitalisation (INF-03), in-depth interview, 3 March 2025).

The findings above are further illuminating this study. The mandate for an essential patient-facing position is assigned to a non-clinical department, which in return results in a possibility of separation between clinical realities and public information. From the perspectives of the patients, the communication is disjointed because they are not aware of the identity of the partners who interact with them on the website. This allocation of responsibility characterises the trait of bureaucratic institutions which frequently contradicts the ideals of patient-centred, dialogic communication, which requires transparent and responsive communication channels (Aridi, 2025; Lu, 2024).

Moreover, challenges in delivering precise information are most accentuated at the point of care, a situation where the healthcare professionals must manage a set of complex situations. The Nursing Manager (INF-05) highlights the intrinsic challenges in guaranteeing that the patients genuinely understand the information:

"Several factors contribute to our communication challenges, moreover in building a productive and solute dialogue with the patients...Language and cultural barriers as well as the patients' of families' emotional state for example...They somehow hinder our comprehension...So we use a feedback method, asking the patients to repeat their

information or concerns and our officers also try our best to repeat our responses.” (Nursing Manager (INF-05), in-depth interview, 3 March 2025).

The feedback method approach indicated in the findings is established as one of the best practices to confirm each other’s understanding. However, the implementation determines whether it serves as an objective of dialogue or merely a one-way verification. This study argues that if the feedback method approach is applied mechanistically, it just validates the acknowledgement of shared information. However, if the hospital can implement the feedback method approach that is applied dialogically, it can facilitate a more meaningful discussion, which in turn enables the healthcare professionals to assess understanding, tackle underlying concerns, and adjust the explanation to the unique conditions of each patient (Lloyd et al., 2023).

The Nursing Manager observes that patient feedback indicates several on-going concerns related to information clarity provided and the intonation used in delivering that information. This particular finding demonstrates that even though positive intentions and established strategies are implemented, the communication gaps remain. In light of this finding, the Vice Director (INF-01) emphasises an organisational perspective which can sustain this disparity, perceiving information as a phenomenon controlled by specific roles:

“First and foremost, naturally, information clarity is the responsibility of the frontline officers or customer service staff who are specifically assigned to provide accurate explanations to the patients...This responsibility is also time-bounded and has to be delivered at the time the service is to be provided.” (Vice Director (INF-01), in-depth interview, 3 March 2025).

The findings further accentuate the framing of information clarity as the sole responsibility of a specific role, which seem sensible from a management standpoint. However, this managerial reality might subtly contradict the principle that communication is a shared, relational activity which must become a common responsibility across the organisation (Keyton & Beck, 2023). This study contends that this possibility of managerial failure risks developing a model in which information is pushed to patients by designated staff, rather than becoming an organisational culture in which every interaction is considered as a chance for a whole-rounded dialogic engagement.

Furthermore, this study argues that this ‘push’ model as demonstrated previously is not just a cultural choice; it is a core rejection of dialogic mutuality. For example, the hospital’s systems, from the one-way queue screen to the siloed IT department, are designed and implemented to manage the patient, which is formatively correct. However, this study recommends an integration of those technical operations with real dialogue in order to engage with the patients as an equal partner. By defining information clarity as a one-way responsibility of the frontline staff, the Vice Director frames communication as a product to be delivered, rather than a process to be co-created. Hence, this monologic strategy strips the patients of their agency, which places them as a passive object in the hospital system, rather than an active, dialogic actor whose input is important in building hospital-patient mutual understanding.

Additionally, this managerial challenge is rooted in a profound lack of willingness to accept risk, a cornerstone of authentic dialogic communication. The PR Supervisor’s assertion that staff provide different explanations and the poorly managed scheduling responsibility reveal a system that hinders transparency. Instead of risking an open, system-wide dialogue about its own internal separation the hospital opts for a disjointed yet safe message, which can be seen as a formality. This organisational fear of vulnerability further creates a profound information gap and ambiguities. Hence, this study strongly recommends the hospital to foster a dialogic environment by preventing one from emerging by withholding the honest and comprehensive information required by all stakeholders in all stages.

Ultimately, the combination of both quantitative and qualitative findings demonstrates beyond operational issues. The challenges that the hospital faces in daily operation are symbiotic symptoms of a fractured dialogue. The concerns and anxiety of an unexplained delay is compounded by the confusion of unclear and contradictory information. This study argues that the combination of these risks for the patient to navigate a system which lacks respect and empathy. Hence, the hospital must focus beyond its own operational mechanics, but also on the relational quality of the patients’ experience. The resulting decline in trust is the inevitable effect

of a system which fails to consider communication as anything more than a one-way or transactional phenomenon.

From reaction to relation: bridging systemic gaps in building a dialogic communication framework

The analysis of infrastructural complaints and service process deficiencies demonstrates that the issues at the private hospital in Malang, Indonesia, are not isolated phenomenon but a result of more profound, systemic failures within its business operation framework. The cycle of unsolved issues and the continuation of ineffective communication indicate a fundamentally reactive model, despite its procedural complexity. This study recommends that the hospital to move from a transactional complaint handling approach to a proactive and relational engagement approach to surpass this cycle of reactivity as well as cultivate genuine patient trust. The implementation of this recommendation requires addressing the systemic problems that prevent effective communication and building a dialogic communication framework with the goal of promoting mutual understanding and a collaborative problem-solving process.

However, the primary challenge to a fully implemented dialogic environment is systemic and structural, a phenomenon recognised at the executive level. The Vice Director (INF-01) accentuates two principal challenges:

"The main obstacles or challenges that we have are the lack of an integrated information system across divisions, which causes response delays, as well as the sectoral ego or silos across units, which hinder collaboration." (Vice Director (INF-01), in-depth interview, 3 March 2025).

The findings above reveal the core source of the fractured dialogue discussed in the previous sub-section. Inconsistent information and process delays are not merely caused by individual staff members but are a predictable effect of a fragmented system (Abbas & Miller, 2025). This study highlights that an integrated information system can be a solution to facilitate swift communication; otherwise, the sectoral ego which the hospital faces can lead each division to prioritise its sectoral objectives rather than the overall patient experience. This fragmentation of psychological factors immediately hinders the chance for a coherent and unified communication with the patient, who must contend with the consequences of these internal fractures or disconnections. Hence, Shuja et al. (2023) argue that an efficient reactive complaint handling cannot resolve this issue; it can only mitigate the consequences.

In light of this problem, the Public Relations (PR) department naturally serves as the main architect of the hospital's communication strategy, utilising several tactics to address patient input and highlight the image of a responsive business organisation. The PR Supervisor (INF-02) highlights the significance of ensuring patients feel appreciated:

"The hospital leadership serves as a crucial role to support and emphasising the importance of patient feedback, not as a threat but as an opportunity for quality improvement. We try to implement through multi-channel communication from tangible media within the hospital like posters to social media platforms." (Supervisor of Public Relations (INF-02), in-depth interview, 3 March 2025).

The findings underscore a top-down strategy implemented through a comprehensive complaint management system and a multi-channel patient communication and education approach, including posters and social media. However, despite the significance of these initiatives, they mainly represent a unilateral communication strategy and a reactive response system. For example, the formal complaints workflow exemplifies a reactive process where a complaint is received, categorised, and escalated, and a follow-up action is documented. Likewise, educating or instructing patients through posters and social media becomes a method of information dissemination rather than a discussion. Despite the fact that those strategies are widely implemented across many business sectors, this study argues that it is a system engineered to address a pre-existing issue. The primary objective, as articulated by the PR Supervisor, is to ensure patients feel acknowledged; however, a truly dialogic framework needs to be elevated to this level of honouring patients like collaborators in the hospital-patient communication framework.

Ultimately, this study proposes the application of Integrated Public Service Communication Flow Model for hospitals, adapted and supported with dialogic communication framework, and digital public relations approaches to address the gap between reactive and relational systems and to solve the systemic challenges of dialogue fracture. The proposed model is an empirically grounded framework derived from both the quantitative analysis of 605 complaint documents and qualitative interviews with hospital executives and operational personnel. The proposed model is not merely theoretical but is constructed in response to documented patterns of recurring infrastructure complaints (31.4%), prolonged waiting times (20.5%), and unclear information delivery (18.7%), as well as interview findings that revealed fragmented interdepartmental coordination, linear complaint handoffs, and performative transparency practices. This approach aims to transform communication from a linear, problem-response flow into a continuous, cyclical, and digitally integrated dialogic framework, as demonstrated in Figure 1.

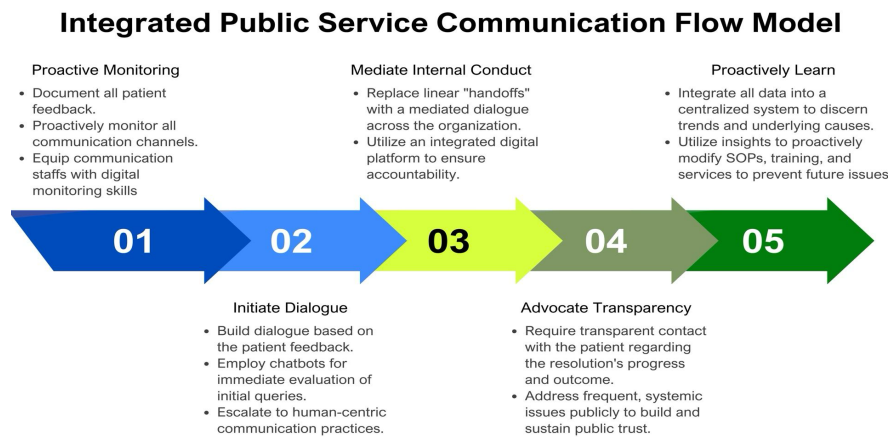


Figure 1. Integrated Public Service Communication Flow Model
 Source: Result of the study (2026)

The proposed model includes five essential stages. The first stage, Proactive Monitoring emphasises the urge to fundamentally shift the hospital's role from a passive receiver of feedback or complaints to an active listener. By documenting all patient feedback, ranging from formal complaints to proactive social media monitoring, into a unified digital system, it results in a real-time and holistic view of the patient experience. This stage is beyond a data collection process; it is about equipping the staff with the digital skills in identifying emerging issues before they escalate, forming the core of a data-driven corporate culture. This dimension is empirically demonstrated by the quantitative finding that 31.4% of complaints concerned infrastructure and 20.5% related to waiting time, indicating recurring issues that could have been detected earlier through systematic monitoring.

The second stage, Initiate Dialogue highlights the importance of a follow-up process or intervention that replaces the currently mechanistic feedback method with a more genuine dialogic communication practice. This stage urges the staff to move beyond simply documenting a complaint to participating in a hospital-patient dialogue. While digital tools like chatbots can be implemented for immediate evaluation, their primary purpose is to efficiently escalate complex problems to human-centric and empathetic communication approaches like direct messages. This stage is built to operationalise mutuality and empathy in order to ensure the patient's experience and expectations are thoroughly managed. This dimension responds to interview findings showing that complaint handling often ceased after administrative closure, leaving patients without meaningful follow-up communication regarding expectations or emotional concerns.

The third stage, Mediate Internal Conduct, demonstrates a clear solution to the sectoral ego and internal fracture, which this study identifies. By replacing linear handoffs with a mediated dialogue across units, the proposed model forces collaboration within the holistic hospital system. This strategy is supported by an integrated digital platform that ensures transparent communication and shared accountability. This stage breaks down the internal silos, which are the root cause of the inconsistent information and unclear decision-making that patients

encounter. This structural reform is grounded in qualitative evidence indicating that complaints categorised under unclear information were frequently linked to fragmented coordination between administrative and clinical departments.

The fourth stage, Advocate Transparency, aims to rebuild the trust that was broken by a performative communication approach that the hospital conducts. It requires the hospital to maintain transparent communication with the patients regarding the progress and outcome of their feedback or concerns simultaneously. More radically, it implements a dialogic communication strategy in addressing frequent, systemic problems, such as pharmacy delays or even the internal management strategy, publicly. This public transparency approach is the practical application of the dialogic principle of risk, in order to demonstrate a commitment to information clarity and honesty which are important to foster sustainable public trust. This dimension is supported by the recurring pattern of complaints related to information clarity, which constituted 18.7 percent of the total dataset and reflected patient dissatisfaction with limited updates on resolution progress.

The final stage, Proactively Learn, is what makes the proposed model cyclical and transformative. All data and outcomes must be integrated into the centralised system, where analytics are leveraged to analyse trends and underlying problems. These insights are beyond filed away; they are integrated to proactively modify SOPs, staff training, and services to prevent future issues. This final stage institutionalised commitment by ensuring the organisation evaluates and learns from every interaction, closing the loop and shifting the entire organisational culture from one of constant reactivity to one of continuous and data-driven improvement. The necessity of this dimension is evidenced by the recurrence of similar complaint categories throughout the nine-month observation period, suggesting that organisational learning mechanisms had not yet translated complaint data into preventive institutional reform.

Implementing this digitally augmented proposed model requires a profound commitment to the fundamental principles of dialogic communication as initiated by Kent and Taylor (2021). The proposed model represents beyond and innovative approach but also a cultural transformation. The proposed model aims to promote mutuality by incorporating patient feedback and concerns as an essential stage and also respecting the patient by regarding them as an equal partner in quality improvement. Additionally, it fosters the hospital-patient proximity by establishing a cohesive digital ecosystem where responses are beyond rapid but also coherent and transparently accessible across all platforms. The focus on active listening and comprehending the patients' perspective during the clarification stage aims to foster empathy, moving beyond procedural handling to embody genuine dialogic communication.

Moreover, implementing these strategies requires the hospital to accept and embrace risks. By committing to transparently communicate with patients through digital platforms, even when an ideal solution is hard to achieve due to financial or other constraints, the hospital opens itself to public scrutiny. This vulnerability constitutes the core significance of trust in the digital era (Wachid et al., 2024). The proposed model's transformational character, wherein digital data analysis embraces systemic learning and proactive adjustments, exemplifies a deep commitment to the long-term hospital-patient relationship. It indicates that the hospital is committed beyond addressing individual complaints but also the continuous improvement of its services through consistent communication improvement with its constituents.

Ultimately, to transform from a state of constant reactivity to one of enduring relational trust, the hospital is forced to address its core systemic problems. The proposed Integrated Public Service Communication Flow model provides a concrete framework for this transformation. By transforming from a fractured and reactive complaint management system to a more cohesive, proactive, and cyclical dialogic communication framework, the hospital is encouraged to implement improvements of its internal divisions, and consequently, foster a genuinely resilient and collaborative hospital-patient relationship. This progression is crucial in advancing the patient experience and reinforcing the hospital's reputation as an entity that proactively listens, learns, and develops in collaboration with its stakeholders.

CONCLUSION

This study, conducted at a prominent private hospital in Malang, East Java, concludes that patient complaints function as significant communicative indicators of the quality of hospital patient relationships. The empirical analysis of 605 complaint records and interviews with hospital executives and frontline personnel demonstrates a fractured dialogue within the organisational complaint management system. Although the system operates with procedural efficiency, it remains predominantly one-way communication. The Malang case reveals that recurring complaints related to infrastructure, waiting time, and information clarity reflect deeper structural communication deficiencies rooted in sectoral ego, fragmented interdepartmental coordination, and limited transparency in service recovery processes. These findings underscore that the communication challenges observed are not incidental but systemic within the studied hospital context.

Based on these empirical insights and analysis, this study proposes the Integrated Public Service Communication Flow Model as a digitally integrated and cyclical framework designed to transform complaint handling from reactive problem resolution into proactive and relational engagement. While the model is grounded in the specific institutional realities of a private hospital in Malang, the identified communication patterns, including procedural closure without dialogic follow-up, internal coordination gaps, and limited transparency, are characteristic of hospital service systems more broadly. Therefore, the Malang case offers analytical generalisation for similar private healthcare institutions operating in competitive urban environments, particularly in relation to complaint communication management. Implementing this model requires organisational cultural transformation grounded in dialogic principles of mutuality, risk, and commitment. Future studies should focus on longitudinal studies in assessing the model's implementation and comparative studies across various diverse healthcare contexts to validate its adaptability.

REFERENCES

- Abbas, R., & Miller, T. (2025). Exploring communication inefficiencies in disaster response: Perspectives of emergency managers and health professionals. *International Journal of Disaster Risk Reduction*, 120, 105393.
- Aboalghanam, K. M., Alzghoul, A., & Alhanatleh, H. (2024). An analysis of service quality and complaint handling in the Jordanian healthcare sector: Implications for TQM and customer retention. *Innovative Marketing*, 20(1), 51.
- Al-Mekhlal, M., Al-Buraik, M., & Al-Lubli, M. (2023). Digital transformation: AI-powered bot solutions and automation for customer services. *2023 International Conference on Digital Applications, Transformation & Economy (ICDATE)*, 1-7.
- Andersen, L. L. (2023). A narrative journey into the borderland of patient safety: Toward an expanded, relational concept of safety. *Qualitative Research in Medicine & Healthcare*, 7(3), 11496.
- Aridi, A. S. (2025). Need for Executive Leadership Coaching in Public Health, Healthcare Administration, Public Safety Crisis Management, and Healthcare Humanitarian Relief. *Health Economics and Management Review*, 6(2), 76-94.
- Babenco, C. (2021). *Culture of Compliance in a Healthcare System: A Qualitative Case Study of Leadership Perceptions Related to Self and Frontline Staff*. Wilmington University (Delaware).
- Bodonyheli, A., Stegemann-Philipps, C., Sonanini, A., Herschbach, L., Szep, M., Herrmann-Werner, A., Festl-Wietek, T., Kasneci, E., & Holderried, F. (2025). Modeling Challenging Patient Interactions: LLMs for Medical Communication Training. *ArXiv Preprint ArXiv:2503.22250*.
- Borson, S., Small, G. W., O'Brien, Q., Morrello, A., & Boustani, M. (2023). Understanding barriers to and facilitators of clinician-patient conversations about brain health and cognitive concerns in primary care: a systematic review and practical considerations for the clinician. *BMC Primary Care*, 24(1), 233.
- Bourne, C. (2022). Public relations and the digital. London, UK, University of London.
- Burke, K., & Leben, S. (2024). Procedural fairness: A key ingredient in public satisfaction. *Ct. Rev.*, 60, 6.
- Chen, L.-H., Chen, C.-H., Loverio, J. P., Wang, M.-J. S., Lee, L.-H., & Hou, Y.-P. (2024). Examining soft and hard attributes of health care service quality and their impacts on patient satisfaction and loyalty. *Quality Management in Healthcare*, 33(3), 176-191.
- Colgan, D. D., Eddy, A., Aulet-Leon, M., Green, K., Peters, B., Shangraw, R., Theard, M. A., Han, S. J., Raslan, A., & Oken, B. (2024). Compassion, communication, and the perception of control: a mixed methods study to investigate patients' perspectives on clinical practices for alleviating distress and promoting empowerment during awake craniotomies. *British Journal of Neurosurgery*, 38(4), 911-922.
- Davenport, F. G. (2022). *Communicating comfort in crisis: a literature review on overcoming the emergency room environment to foster the nurse-patient relationship*.
- Denzin, N. K., & Lincoln, Y. S. (2023). *The Sage handbook of qualitative research*. sage.
- El-Adly, M. I., Souiden, N., & Khalid, A. (2024). The impact of emotional perceived value on hotel guests' satisfaction, affective commitment and loyalty. *Consumer Behavior in Tourism and Hospitality*, 19(4), 551-567.
- Feldman, S. S., Kennedy, K. C., Nafziger, S. M., Orewa, G. N., Kpombekou-Ademawou, E., Hearld, K. R., & Hall, A. G. (2022). Critical success factors for addressing discharge inefficiency at a large academic medical center: A Lean Six Sigma approach. *Journal of Nursing Care Quality*, 37(2), 135-141.

- Filip, R., Gheorghita Puscaselu, R., Anchidin-Norocel, L., Dimian, M., & Savage, W. K. (2022). Global challenges to public health care systems during the COVID-19 pandemic: a review of pandemic measures and problems. *Journal of Personalized Medicine*, 12(8), 1295.
- Gartner, J.-B., Abasse, K. S., Bergeron, F., Landa, P., Lemaire, C., & Cote, A. (2022). Definition and conceptualization of the patient-centered care pathway, a proposed integrative framework for consensus: a concept analysis and systematic review. *BMC Health Services Research*, 22(1), 558.
- George, G., Chaturvedi, S., Corbishley, C., & Atun, R. (2024). Relational co-ordination and stigma at work: How frontline employees compensate for failures in public health systems. *Journal of Management Studies*, 61(3), 752-784.
- Gerken, A. T., Öngür, D., Kim, S. J., Ren, B., Idiculla, T., & Stoklosa, J. (2025). Patient-Centered Communication: Incorporating Principles of Dialogic Practice and Family Centered Rounds on an Inpatient Psychotic Disorders Unit. *Community Mental Health Journal*, 61(2), 394-400.
- Güllüpinar, M. D. (2023). A Qualitative Study to Explore the Perceptions of Health-Care Professionals on the Use of Dialogic Communication Tools in Health Institutions. *Communicata*, 26, 23-30.
- Havana, T., Kuha, S., Laukka, E., & Kanste, O. (2023). Patients' experiences of patient-centred care in hospital setting: A systematic review of qualitative studies. *Scandinavian Journal of Caring Sciences*, 37(4), 1001-1015.
- Kent, M. L. (2023). Dialogic theory in public relations. In *Public relations theory III* (pp. 133-150). Routledge.
- Kent, M. L., & Taylor, M. (2021). Fostering dialogic engagement: Toward an architecture of social media for social change. *Social Media+ Society*, 7(1), 2056305120984462.
- Keyton, J., & Beck, S. J. (2023). Relational communication in groups. In *Group Communication* (pp. 147-160). Routledge.
- Kim, E.-J., Koo, Y.-R., & Nam, I.-C. (2024). Patients and healthcare Providers' perspectives on patient experience factors and a model of patient-centered care communication: a systematic review. *Healthcare*, 12(11), 1090.
- Kooijman, A., & Canfield, C. (2024). Cultivating the conditions for care: it's all about trust. *Frontiers in Health Services*, 4, 1471183.
- Lloyd, R., Munro, J., Evans, K., Gaskin-Williams, A., Hui, A., Pearson, M., Slade, M., Kotera, Y., Day, G., & Loughlin-Ridley, J. (2023). Health service improvement using positive patient feedback: Systematic scoping review. *PLoS One*, 18(10), e0275045.
- Lu, W. (2024). *Examining the effects of empathy and dialogic risk communication in physicians' text-based messages on patient satisfaction and compliance in Chinese online medical consultations*.
- Mahlangu, T. (2024). *Building communicative organisation-stakeholder relationships through dialogue on social networking sites: a network perspective*. University of Johannesburg (South Africa).
- Nartey, L. J., Henisz, W. J., & Dorobantu, S. (2023). Reciprocity in firm-stakeholder dialog: Timeliness, valence, richness, and topicality. *Journal of Business Ethics*, 183(2), 429-451.
- Nguyen, N. X., Tran, K., & Nguyen, T. A. (2021). Impact of service quality on in-patients' satisfaction, perceived value, and customer loyalty: A mixed-methods study from a developing country. *Patient Preference and Adherence*, 2523-2538.
- Nyambo, E. (2024). When Doctor-Patient Discourse Isn't Adequate: Social Media Health Multimodal Dialogic Discourse Analysis. In *The Palgrave Handbook of Language and Crisis Communication in Sub-Saharan Africa* (pp. 325-342). Springer.
- Omari, F., Hamid, A. B. A., & Ya'akub, N. (2023). *Why and how patients complain: Decoding patterns of patient complaint behaviour in private and public hospitals*.
- Poth, C. N. (2023). *The Sage handbook of mixed methods research design*.
- Sembiring, D. C., Aulia, D., & Juanita, J. (2024). Analisis Perbedaan Karakteristik Pasien terhadap Preferensi Pasien Rawat Jalan BPJS-Kesehatan di Rumah Sakit Kelas B Milik Swasta dan Pemerintah. *MAHESA: Malahayati Health Student Journal*, 4(11), 5060-5076.
- Shisundi, P. Y. (2023). *Factors influencing patient waiting time in emergency department of Khunyangu Sub-County hospital, Kenya*.
- Shuja, A., Awan, M. I., & Saleem, I. (2023). Cotton Web Limited: a journey from disintegrated complaint handling to an efficient and robust e-complaint management system. *Emerald Emerging Markets Case Studies*, 1-19.
- Subramaniam, S. H., Wider, W., Tanucan, J. C. M., Yew Lim, K., Jiang, L., & Prompanyo, M. (2024). Key factors influencing long-term retention among Contact Centre employee in Malaysia: a Delphi method study. *Cogent Business & Management*, 11(1), 2370444.
- Thamrin, H., Ridho, H., Saragih, I. D., & Pirandy, G. (2025). Exploring social determinants of health and their influence on quality of life and social welfare in Indonesia: a comprehensive review. *Retos: Nuevas Tendencias En Educación Física, Deporte y Recreación*, 68, 1497-1517.
- Venuleo, C., Marinaci, T., Cucugliato, C., & Giausa, S. (2024). It is time to take complaints seriously? An exploratory analysis of communications sent by users to a public healthcare agency before, during and after the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, 21(10), 1299.
- Wachid, I. B., Wulandari, M. P., & Nasution, Z. (2024). Evolving human resource dimension in Indonesia's digital public relations landscape. *Jurnal Studi Komunikasi*, 8(2), 441-450.
- Werder, O. (2024). *Transformational Health Communication*. Springer.
- Widarna, R., Afifah, N., Djunaedy, H. A. K., Sassi, A., Vasquez, N. A., Oga-Omenka, C., Salindri, A. D., Lestari, B. W., Pai, M., & Alisjahbana, B. (2024). The shifting landscape of private healthcare providers before and during the COVID-19 pandemic: Lessons to strengthen the private sectors engagement for future pandemic and tuberculosis care. *PLoS Global Public Health*, 4(10), e0003112.
- Yamada, A. (2025). Patient-healthcare Professional Dialog from the Patient's Perspective: Concept Analysis Based on Literature Review. *Journal of Patient Experience*, 12, 23743735251324396.