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Optimizing Islamic Work Culture to Improve Outpatient Service Excellence at Sakinah Islamic Hospital, Mojokerto

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ABSTRACT

Islamic hospitals are expected to embed Sharia-based moral principles into every point of patient contact, yet many still struggle to translate this identity into consistent staff behavior. At Sakinah Islamic Hospital (RSI Sakinah) in Mojokerto, a type-C hospital, patient complaints concentrated in the outpatient unit and centered on non-technical issues such as unfriendliness, unclear queuing, and indifference toward new patients. This study examined how far Islamic core values are enacted in outpatient staff behavior and proposed a strategy to close the resulting gap. Using a descriptive qualitative case-study design, data were drawn from non-participatory Time-Motion Study (TMS) observation across shifts, internal document review, a twelve-month sample of ninety-two negative online reviews, and confirmatory discussion with hospital management. Root causes were mapped using a Fishbone (5M) diagram combined with the 5-Why technique, alternative solutions were generated through a focus group discussion, and prioritization was carried out with the Capability-Accessibility-Readiness-Leverage (CARL) method. The analysis found that service shortfalls stemmed less from a lack of technical resources than from the absence of any mechanism translating the hospital's Islamic identity into measurable staff behavior. Two interventions received the highest CARL scores: value-based service-excellence training built around ihsan and rahmah, and the integration of Islamic core values into standard operating procedures and performance appraisal. Beyond confirming that Islamic work ethics correlate with service outcomes, this study contributes a replicable diagnostic-to-intervention pathway (combining Fishbone-5Why root-cause analysis with CARL prioritization) that operationalizes abstract Islamic values into concrete, auditable behavioral indicators for hospital management

1. Introduction

Under Law No. 17 of 2023 on Health, every hospital in Indonesia is obliged to deliver promotive, preventive, curative, rehabilitative, and palliative services that are safe, high-quality, and accessible (Presiden Republik Indonesia, 2023). Because hospitals typically represent the last resort when people seek to restore or maintain their health, the way a patient is treated during that visit tends to shape their overall judgment of the institution far more than clinical outcomes alone (Zainur and Tanjung, 2021). Service quality in this sense is no longer confined to medical competence; it now hinges on whether patients feel heard, respected, and cared for throughout the encounter.

For Islamic hospitals, this expectation carries an additional layer. Beyond generic service standards, the ir identity is built on Sharia-derived principles such as shiddiq (truthfulness), amanah (trustworthiness), fathanah (intelligence), tabligh (communicativeness), and iqtan (excellence in work), values meant to be visible in everyday interactions rather than confined to institutional slogans (Darmawan & Asyhari, 2025). When these values

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remain declarative (written into a vision statement but absent from actual staff conduct), the mismatch does more than disappoint individual patients; it erodes the credibility of the "Islamic hospital" label itself (Ali, 2019).

RSI Sakinah Mojokerto illustrates this tension. Its vision, "to become a professional Islamic hospital, the pride of patients and families," and its mission of serving with a smile, greeting, and warm welcome position Islamic identity at the center of its brand promise. As a type-C hospital with 232 beds and roughly 460 medical and non-medical staff, however, a preliminary review of ninety-two negative online reviews collected over a one-year period found that 64% of complaints originated from interactions in the outpatient unit, describing staff as curt, indifferent toward first-time patients, or unclear about queuing procedures. Read against the hospital's own stated values, complaints of rudeness sit uneasily beside the principle of iqtan, and indifference sits uneasily beside amanah, a discrepancy several authors describe as an identity-behavior gap capable of quietly undermining public trust even where clinical quality is adequate (Ali, 2019; Zainur & Tanjung, 2021).

The outpatient unit was chosen as the focus of this study precisely because it functions as the hospital's frontline: it is usually the first point of contact for patients, it generates the largest share of service complaints, and it disproportionately shapes overall patient experience. Addressing the gap there therefore offers the clearest test of whether Islamic core values can be moved from documentation into daily practice.

The proposition that Islamic work ethics (IWE) shape employee behavior and organizational outcomes is well established in Indonesian hospital scholarship; studies such as Ali (2019) and Darmawan and Asyhari (2025) have repeatedly shown positive associations between Islamic work culture and patient satisfaction or staff performance, typically through cross-sectional surveys. What remains comparatively underdeveloped is a documented, step-by-step pathway for moving from that general association to a concrete, hospital-specific intervention, one that a quality-improvement team could realistically replicate. This study seeks to fill that gap in three respects. First, rather than relying on a single survey instrument, it triangulates behavioral observation, document review, and patient-generated review data to diagnose where and why the identity-behavior gap occurs, offering a qualitative complement to the predominantly quantitative IWE literature. Second, it applies a Fishbone-5Why root-cause analysis in combination with CARL prioritization to move systematically from symptom to root cause to a ranked set of feasible interventions. Third, and most concretely, it translates abstract IWE constructs (shiddiq, amanah, tabligh, fathanah) into operational artifacts: a training curriculum, a revised performance-appraisal instrument, and a staff pocket guide, each carrying measurable behavioral indicators rather than aspirational language. The contribution of the study therefore lies less in confirming that Islamic values matter and more in demonstrating a replicable diagnostic-to-intervention model that other Islamic hospitals facing similar gaps could adapt.

2. Theory

2.1. Islamic Work Ethics and Work Culture

Work culture, understood here as the pattern of shared values and habitual behavior that guides how a specific group of employees carries out its daily tasks, is the more precise construct for this study than organizational culture in the broader Cameron-and-Quinn sense, since the phenomenon under investigation is confined to observable service behavior within one unit rather than the hospital's overall organizational typology. Within that narrower frame, Islamic Work Ethics (IWE) offers the most directly relevant theoretical lens. Ali (1988) conceptualizes IWE as a value orientation that treats work as a form of worship and a vehicle for social contribution, emphasizing effort, cooperation, and moral responsibility over mere output. Yousef (2001) extends this by showing that IWE moderates the relationship between organizational commitment and job satisfaction across cultural settings, suggesting that its effects operate through employees' internalized sense of duty rather than through external incentives alone.

More recent evidence reinforces this behavioral pathway. Udin et al. (2022) found that IWE improves employee performance primarily through affective commitment, while Ateeq et al. (2025) reported a similar mediation effect on task performance. Suryani (2023) further documented that a well-internalized Islamic work culture can raise behavioral consistency by up to 62% once it functions as a clear moral compass for staff. Read together, this body of work implies that Islamic values shape service behavior mainly when they are internalized and reinforced by organizational systems (training, supervision, and appraisal), rather than when they exist only as stated principles.

2.2. The Value-Behavior Gap and Institutional Theory

The gap between an organization's declared values and its members' actual conduct has long been theorized in institutional analysis. Meyer and Rowan (1977) describe how organizations often adopt formal structures and stated commitments to secure legitimacy from external audiences while day-to-day operational routines continue largely unchanged - a pattern they call decoupling. DiMaggio and Powell (1983) similarly argue that organizations frequently converge on symbolically legitimate identities without a corresponding change in internal practice, particularly where enforcement mechanisms are weak. Applied to RSI Sakinah, this suggests that the identity-behavior gap identified in the introduction is not simply a matter of

individual staff attitude; it is also a structural symptom of a vision and mission that remain decoupled from the operational instruments (SOPs, appraisal systems, supervision routines), that would otherwise compel their enactment. Schein's (2010) account of organizational culture is used here only as a supporting explanation of how such gaps persist once formed, rather than as the primary analytical framework.

2.3. Service Excellence in Healthcare

The concept of Islamic Work Ethics (IWE) teaches Service excellence in healthcare extends beyond technical competence to include empathy, responsiveness, and sensitivity to patient needs (Guglielmetti Mugion et al., 2020). Prakoso (2023) notes that hospitals able to embed these behaviors into frontline routines are better positioned to sustain patient loyalty amid growing public scrutiny of service quality, while Astuti et al. (2024) emphasize that outpatient registration and reception points are especially decisive for overall satisfaction because they form patients' first impression of the institution. For an Islamic hospital, service excellence and Islamic work ethics are therefore not parallel goals but overlapping ones: the behaviors that define service excellence (courtesy, attentiveness, timely communication), are largely the same behaviors that operationalize shiddiq, tabligh, and ihsan in practice.

3. Research Method

This study used a descriptive qualitative case-study design to examine the misalignment between RSI Sakinah's stated Islamic values and the actual service behavior of its outpatient staff. A case-study approach was chosen because the object of inquiry (a single unit's service behavior within its organizational and cultural context), is best understood through in-depth, context-bound analysis rather than cross-site comparison or statistical generalization. The study was conducted at RSI Sakinah Mojokerto, a type-C Islamic hospital, with the outpatient unit as the unit of analysis because it is the point of highest patient contact and the primary source of service complaints.

Data were drawn from four sources. First, non-participatory behavioral observation was conducted across a minimum of three sessions spanning different shifts between 6 August and 10 October 2025, using a Time-Motion Study (TMS) approach that recorded verbal and non-verbal staff-patient interaction, response time, and the handling of patients with special needs; eight patient encounters were documented in analytic detail. Second, internal documents were reviewed, including the outpatient registration SOP, pharmacy guidelines, the existing performance-appraisal instrument, the 2024 annual report, and National and Hospital Quality Indicator reports for the first quarter of 2025. Third, ninety-two negative online reviews (one- to four-star ratings) posted over the preceding twelve months were read repeatedly and grouped manually by service unit and complaint theme (interaction quality, queuing procedure, and new-patient orientation); this categorization was exploratory rather than a formal computer-assisted thematic or content analysis. Fourth, findings were discussed and confirmed with the field supervisor, the academic supervisor, and relevant section managers in two structured review sessions, together with a focus group discussion (FGD) involving six to eight multidisciplinary staff convened specifically to generate and vet alternative solutions.

For the prioritization stage, eight respondents representing distinct hospital units (medical services, inpatient ward, accounting, general affairs, environmental services, spiritual affairs/Binroh, and central sterile supply) independently rated each candidate solution using the CARL instrument. Preliminary problem identification took place between 6 and 27 August 2025 through eight rounds of exploratory fieldwork combining direct observation with informal discussion with unit staff and management, from which sixty-two candidate problems were compiled and subsequently narrowed (through thematic grouping and an Input-Process-Output classification), to twelve priority issues. These were then ranked using the Urgency-Seriousness-Growth (USG) method via a structured questionnaire completed by hospital staff, from which “inconsistent work culture and staff/attending-physician discipline” emerged as the top-ranked problem and became the focus of this study. Field data collection proper then ran from 8 to 17 September 2025, at a frequency of two to three site visits per week.

Root-cause analysis combined a Fishbone (Ishikawa) diagram across five categories (Man, Method, Machine, Material, and Mother Nature), with the 5-Why technique to trace each symptom back to its underlying cause. Candidate solutions were generated by combining FGD output with a brief evidence-based literature check, then prioritized using the Capability-Accessibility-Readiness-Leverage (CARL) method. Each of the eight raters scored every candidate solution on each CARL criterion using a four-point ordinal scale (1 = Low, 2 = Fair, 3 = High, 4 = Very High); the eight ratings for each criterion were summed (maximum possible sum = 32) to produce a criterion score, and the four criterion scores were multiplied ($C \times A \times R \times L$), following common CARL practice in Indonesian public-health quality-improvement work.

Credibility was supported through triangulation of the TMS observation data with document review and confirmatory discussion during the two supervisory review sessions, which functioned as a form of peer debriefing on emerging findings (Lincoln & Guba, 1985). Even so, several design limitations should be noted rather than obscured. No formal data-saturation criterion was pre-specified for the exploratory interviews, and informant selection followed convenience and management referral rather than a structured maximum-variation sampling strategy; the precise number of managerial informants consulted during the confirmatory

stage was not systematically logged. Frontline staff perspectives were captured primarily through direct behavioral observation rather than formal interviews, which may understate their own interpretation of the barriers they face. The analysis of the ninety-two online reviews relied on manual reading and categorization rather than a documented coding protocol, so the 64% figure should be read as an indicative rather than a fully audited estimate. These limitations are revisited in the Discussion.

4. Results

The ninety-two negative reviews collected over the preceding year converged on three recurring themes: brusque or impatient treatment at registration, unclear queuing procedures, and a lack of guidance for first-time patients. Several reviewers explicitly contrasted the hospital's Islamic branding with their experience, questioning why an institution identifying itself as an Islamic hospital would tolerate curt or dismissive treatment. Taken together, these accounts corroborate the quantitative pattern reported in the introduction and indicate that the perceived gap is not an isolated incident but a recurring feature of outpatient interactions.

TMS observation of eight documented patient encounters revealed uneven service behavior. A minority of interactions showed staff greeting patients with a smile and providing clear direction. In most encounters, however, empathetic engagement was minimal: a wheelchair-using patient was addressed only from a distance rather than assisted directly; patients submitting prescriptions at the pharmacy counter received no greeting; and several encounters proceeded without eye contact or a closing courtesy. While service was generally fast and procedurally correct, the dimensions of empathy, attentiveness, and Islamic communicative courtesy were largely absent from routine practice.

Combining the Fishbone diagram with the 5-Why technique indicated that the root problem was not primarily technical but systemic: Islamic values had not been built into the management systems that shape daily staff behavior. Table 1 summarizes the analysis across the five 5M categories.

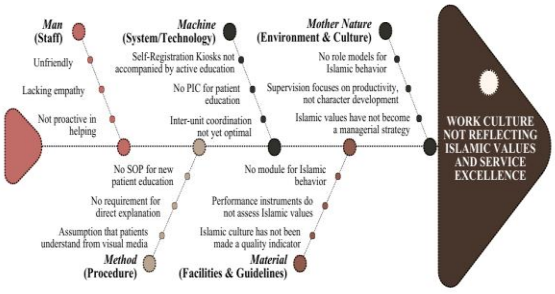

Figure 1. *Fishbone Diagram*
Source: Processed Data (2025)

Table 1. Root-Cause Analysis

Category (5M)	Main Problem Description
Man (Staff)	**Observed Problem**: Front-office and pharmacy staff show low friendliness and limited proactive assistance toward new or vulnerable patients. **Underlying Cause**: Islamic behavior is not habitual because service training covers technical tasks only → no Islamic-values training module exists → no such module is required because Islamic behavior is not a performance-appraisal indicator → the appraisal system still targets discipline and productivity only.
Method (Procedure)	**Observed Problem**: New patients receive no direct orientation to the registration flow, causing confusion and uncertain waiting **Underlying Cause**: Staff do not explain the flow because the registration SOP does not require it → the SOP assumes patients already understand the flow from banners/online media → this assumption is never evaluated → monitoring targets service speed, not patient experience.
Machine (System)	**Observed Problem**: The self-registration kiosk is available but under-used because patients do not understand it and staff do not proactively assist. **Underlying Cause**: Socialization of the kiosk relies only on banners and screens → it is not built into the registration workflow → inter-unit coordination is sub-optimal → no staff member is designated as the patient-education contact point.
Material (Guidelines)	**Observed Problem**: No instrument exists to monitor whether staff behavior reflects Islamic values. **Underlying Cause**: The appraisal instrument measures only discipline and output → Islamic behavior was never integrated into the appraisal guide → Islamic work culture has not been adopted as an organizational quality indicator → management has not built a monitoring system for it.
Mother Nature (Culture)	**Observed Problem**: Islamic culture is not visibly modeled in daily front-office and pharmacy interactions. **Underlying Cause**: Implementation of Islamic values is not measured → it is not integrated into supervision → supervision instead prioritizes productivity under time pressure → management has not yet committed to Islamic culture as a strategic indicator.

Source: Processed Data (2025)

Overall, the analysis points to the same structural pattern across all five categories: the deficiency is not a shortage of facilities or staff competence but the absence of any system that renders Islamic values visible, trainable, and measurable in daily service. Figure 1 presents the Fishbone diagram in full

Table 2 consolidates the five root-cause categories into two overarching themes, offering a reader-friendly map of how the specific findings in Table 1 relate to the broader intervention areas.

Table 2. Thematic Map of Root Causes and Corresponding Intervention Areas

Overarching Theme	5M Categories Involved	Core Sub-Theme	Related Intervention Area
Uninternalized individual behavior	Man	Islamic values not habitual in day-to-day interaction; training limited to technical skills	Value-based service-excellence training
Absent systemic reinforcement	Method, Machine, Material, Mother Nature	No SOP requirement, no monitoring instrument, no supervisory emphasis on Islamic behavior	Integration of Islamic values into SOPs and performance appraisal

Source: Processed Data (2025)

Five candidate interventions were generated through the FGD and evidence-based review: (1) Islamic service-excellence training grounded in ihsan and rahmah; (2) integration of Islamic core values into service SOPs and performance appraisal; (3) an Islamic service-ethics pocket guide; (4) appointment of Islamic work-culture role models in each unit; and (5) value-based supervision and coaching.

Table 3. CARL Method Analysis and Ranking

No	Alternative Solution	Total CARL Score	Rank
1.	Islamic service-excellence training grounded in ihsan and rahmah	837.000	1
2.	Integration of Islamic core values into service SOPs and performance appraisal	837.000	1
3.	An Islamic service-ethics pocket guide	755.160	3
4.	Appointment of Islamic work-culture role models in each unit	706.440	4
5.	Value-based supervision and coaching	783.000	2

Source: Processed Data (2025)

The two top-ranked interventions scored highest on all four criteria, indicating that raters across units judged them as both highly feasible and highly consequential. This convergence across independently rated criteria strengthens confidence that the two interventions address the dominant root causes identified in Table 1 rather than a peripheral symptom.

5. Discussion and Conclusion

The findings indicate that RSI Sakinah's identity-behavior gap is best explained not as a failure of individual character among outpatient staff but as an instance of the decoupling described by Meyer and Rowan (1977): a vision and mission publicly declared to secure legitimacy as an "Islamic hospital," while the operational instruments capable of enforcing that identity in daily practice (SOPs, supervision, and appraisal), were never built to carry it. This reading helps explain why the gap persists despite an explicit and repeatedly communicated Islamic mission: institutional theory suggests that symbolic commitments tend to survive without behavioral change precisely when, as in this case, no measurement or accountability mechanism links the two (DiMaggio & Powell, 1983). Viewed this way, the intervention priority indicated by the CARL analysis, training paired with SOP and appraisal integration, is not simply a service-improvement measure but an attempt to re-couple the hospital's stated identity with its operational systems.

It is worth engaging critically with evidence that complicates this optimistic reading. While Udin et al. (2022) and Ateeq et al. (2025) report that Islamic work ethics improve performance through affective commitment, Udin et al. (2022) also note that Khan and Rasheed (2015), along with more recent studies by Aflah et al. (2021) and Elahi et al. (2020), found no significant relationship between Islamic work ethics and employee performance. This inconsistency across the wider literature suggests that IWE's behavioral effect is conditional rather than automatic, it may depend on factors such as leadership consistency, organizational size, or the presence of enforcement mechanisms that this study did not measure directly. For RSI Sakinah, this implies that training and SOP integration, however well designed, are unlikely to close the gap on their own unless accompanied by sustained managerial commitment and consistent role-modeling by supervisors, a condition the Fishbone analysis found notably absent under the Mother Nature category.

The results also extend the service-excellence literature's emphasis on consistency between external branding and internal reality (Astuti et al., 2024). A hospital that markets itself as Islamic while tolerating curt registration behavior does not merely under-deliver on a generic service promise; it creates a more specific form of dissonance, since patients evaluating an explicitly religious institution may apply a stricter standard of moral conduct than they would to a secular provider. This may explain why several of the reviews examined singled out the hospital's Islamic identity when expressing dissatisfaction, rather than simply describing the service failure in generic terms.

Several limitations, should temper how these conclusions are generalized. This is a single-site case study conducted over one internship cycle (August-October 2025), so the findings describe a particular hospital at a particular moment rather than a generalizable pattern across Islamic hospitals. The informal, convenience-based sampling of managerial informants and the absence of a pre-specified data-saturation criterion mean that some perspectives (particularly those of frontline staff, who were observed rather than interviewed), may be under-represented relative to management's. Finally, because the analysis of online reviews was exploratory rather than based on a documented coding protocol, the reported complaint proportions should be treated as indicative evidence supporting triangulation rather than as a stand-alone quantitative result.

This study set out to examine how far RSI Sakinah Mojokerto's declared Islamic values are enacted in outpatient staff behavior, and to propose a strategy for closing the resulting gap. The evidence points to a work culture in which Islamic values remain declarative rather than operational: staff behavior, service procedures, and performance appraisal have not yet been systematically aligned with the hospital's Islamic identity, producing a value-behavior gap that surfaces in patient complaints and inconsistent service encounters. Two interventions: 1) Islamic service-excellence training and 2) The integration of Islamic values into SOPs and performance appraisal, emerged as the highest-priority responses under CARL analysis, and are best implemented together, since training builds individual capacity while systemic integration sustains it.

Beyond its practical relevance to RSI Sakinah, the study offers Islamic hospitals more broadly a replicable diagnostic sequence (triangulated observation, Fishbone-5Why root-cause analysis, and CARL prioritization), for moving from a general commitment to Islamic values toward a concrete, auditable intervention package. Future research could usefully test whether the proposed interventions produce measurable behavioral change once implemented, ideally through a longitudinal or multi-site design that addresses the single-site and single-period limitations of the present study, and could examine more directly the leadership and enforcement conditions under which Islamic work ethics reliably translate into service behavior.

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