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Between Symbols and Service: Inclusive Leadership in Faith-Based Hospitals, Identity Safety, and Interfaith Patient Trust in Yogyakarta

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Abstract

General Background: Faith-based hospitals in Yogyakarta operate within a pluralistic society where patient trust is shaped by both clinical competence and identity-sensitive service cues.**Specific Background:** Inclusive leadership is theorised to reduce identity threat and enhance fairness perceptions, yet empirical evidence on its effects for interfaith patients remains limited.**Knowledge Gap:** Existing studies have not clarified how leadership-driven identity-safe cues and justice perceptions jointly influence trust, affective comfort, and patient behavioural outcomes in faith-based healthcare. **Aims:** This study examines a structural model linking inclusive leadership, identity-safe religious cues, procedural/interactional justice, trust, comfort, satisfaction, and post-service behaviour. **Methods:** A cross-sectional survey of 114 outpatients from two urban hospitals was analysed using PLS-SEM. **Results:** Inclusive leadership strongly predicted identity-safe cues and fairness perceptions, which in turn significantly increased trust; trust enhanced comfort, driving satisfaction, revisit intention, and positive word of mouth. **Novelty:** This study reframes inclusive leadership as a consumer-facing signal of warmth, competence, and interfaith respect, advancing identity-safety theory into healthcare consumption. **Implications:** Hospitals should institutionalise inclusivecuearchitecture and transparent procedures to strengthen trust, elevatepatientexperience, and reinforce competitive advantage.

Highlights:

- Inclusive leadership strengthens identity-safe religious cues and fairness signals.
- Trust and affective comfort act as key mediators toward satisfaction and loyalty.
- Identity-safe service design enhances interfaith patient experience and hospital competitiveness.

Keywords: Inclusive Leadership, Identity-Safe Cues, Trust, Patient Comfort, Faith-Based Hospitals

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Introduction

Yogyakarta is known as an educational city with a pluralistic society and a strong healthcare ecosystem, including faith-based hospitals. In this landscape, trust is the psychological currency that determines the choices, loyalty, and communication of patients across faiths. Consumer psychology literature shows that consumer judgements—including those of patients are shaped by cues that represent the goodwill and capabilities of service providers. The Stereotype Content Model emphasises two universal dimensions of social judgement: warmth (goodwill/honesty) and competence, which systematically shape trust and behaviour [1]. In the hospital context, patients assess not only clinical competence, but also policy signals and leadership communication that convey interfaith goodwill a foundation for consumer trust in healthcare services.

At the same time, healthcare research confirms that patient experience positively correlates with clinical safety, effectiveness, and operational outcomes, making it strategically valuable beyond mere "comfort" [2]. Multi-hospital studies also show a relationship between patient satisfaction and a decrease in 30-day readmission rates, reinforcing that the patient perspective contributes to system quality [3]. Thus, investing in experiences that build trust is not only ethical, but also impacts hospital clinical performance and reputation.

From a psychological perspective, trust is the belief that others possess benevolence, integrity, and ability [4]. This framework is useful for mapping how patients assess hospitals: benevolence targets interfaith goodwill; integrity refers to policy consistency and fairness; ability relates to clinical competence. Research in healthcare also places trust at the centre of doctor-patient relationships, influencing compliance, retention, and recommendations [5]. In the context of faith-based hospitals, the trust of patients of different faiths will largely be determined by leadership signals that affirm interfaith respect and clinical quality.

This is where inclusive leadership becomes key. Organisational research in hospitals shows that leader inclusiveness characterised by openness, accessibility, and appreciation for diverse contributions—increases psychological safety so that people dare to speak up and engage in improvement [6]. Although the original focus of this study was on clinical teams, consumer implications arise when inclusive leadership practices are manifested in policies, facilities, and communication that "make patients feel safe in their identity." In other words, inclusive leadership functions as a market signal that patients read as warmth (goodwill) while also conditioning fair interactions (procedural/interactional justice).

The concept of identity safety from social psychology provides a theoretical bridge to link leadership with consumer behaviour. Purdie-Vaughns et al. (2008) show that diversity/identity-safe cues—such as representation and value statements can reduce identity threats and increase trust in institutions [7]. Applied in faith-based hospitals, inclusively designed religious cues (multi-faith worship spaces, neutral communication guidelines, diet/ritual policies) can reduce concerns among patients of different faiths that they will be treated inferiorly. Thus, inclusive leadership that actively orchestrates these cues has the potential to increase trust and comfort, which in turn affects satisfaction, intention to return, and word of mouth.

The literature on organisational justice complements the psychological mechanisms. Procedural justice and interactional justice have been found to be relevant in explaining affective responses and behaviour in services—including healthcare as both communicate respect and openness of explanation [8]. In outpatient clinics, for example, queue transparency and examination status explanations are signals of fairness which, when curated by leaders, enrich perceptions of warmth and integrity.

Research in Indonesia on Sharia-based and faith-based hospitals shows the relevance of religiosity-linked cues to patient attitudes, satisfaction, and loyalty. A study on Sharia hospitals found that Sharia service standards and commitment to religiosity through trust have implications for attitudes and loyalty [9]. These findings confirm that when cultural/religious values are clearly and fairly signalled, trust increases—but a knowledge gap remains regarding how leadership designs effective identity-safe cues for interfaith patients, especially in a pluralistic city like Yogyakarta.

Compiling the above flow, this article proposes a model centred on consumer psychology: inclusive leadership → identity-safe religious cues and perceptions of fairness (process & interaction) → trust (benevolence, integrity, competence) → affective comfort → satisfaction, revisit intention, and WOM. The warmth–competence dimension provides a framework for categorising cues; the trust model guides the operationalisation of constructs; and the literature on patient experience validates the relevance of clinical and managerial outcomes [1]–[4]. Theoretically, the contributions of this article are (1) shifting the lens of leader inclusiveness from intra-organisation to the patient market through the mechanism of identity safety, and (2) mapping the specific warmth–competence pathway in cross-religious healthcare consumption. Practically, this article provides policy/communication designs for faith-based hospital leaders in Yogyakarta to reduce identity threats, foster trust, and ultimately strengthen clinical performance and hospital reputation.

Finally, the urgency of this study is reinforced by public accountability demands for quality and patient experience. Evidence that better experiences are associated with clinical safety and effectiveness underscores the need for inclusive leadership architecture—not merely a marketing approach—to ensure cross-faith service equity. In Yogyakarta, with its diversity of religious institutions and faith-based hospitals, the quality of leadership signals that frame universal values (respect, justice, transparency) has the potential to be a key differentiator in building consumer trust and hospital competitive advantage.

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Method

A. Design and Setting

This study used a quantitative cross-sectional survey design to test a theoretical model linking inclusive leadership with identity-safe religious cues, procedural and interactional justice, trust (benevolence, integrity, competence), and patient affective comfort. Data collection was conducted at two faith-based hospitals in the urban area of the Special Region of Yogyakarta, which have a multi-faith patient base and busy outpatient services. As part of the author's research agenda, this study was conducted in coordination with local quality management, adhering to the principles of the Declaration of Helsinki and obtaining relevant institutional ethical approval.

B. Population, Criteria, and Sample

The target population was outpatients aged ≥18 years who had recently received services (≤3 months) at both hospitals. Inclusion criteria: (1) able to read/write Indonesian; (2) in stable clinical condition; (3) willing to provide written consent. Exclusion criteria: cognitive/psychiatric conditions that hindered the completion of the self-administered instrument. The sampling technique was consecutive sampling during peak registration and pharmacy hours until the quota was met.

A total of 114 respondents participated (response rate 78.6% of 145 approaches). The demographic characteristics collected included age, gender, education, financing status (JKN/non-JKN), frequency of visits, religious affiliation, and level of religious centrality (for moderator analysis at the exploratory stage). The sample size justification followed PLS-SEM recommendations for models with moderate complexity, where the rule-of-thumb based on the most indicators per construct/largest arrow direction and simulation showed adequacy at n≈100–150 for stable parameter estimation with non-normal distribution [10], [11].

C. Data Collection Procedure

The field procedure was conducted as an exit survey. Trained enumerators picked up prospective participants in the pharmacy/administration waiting area, explained the purpose of the research, and obtained informed consent. The self-administered questionnaire was completed on paper or digital devices; enumerators only assisted when asked for language clarification, without directing answers. The average completion time was 12–15 minutes. To minimise social-desire bias, enumerators did not come from the same service unit and ensured complete confidentiality. There were no financial incentives; participants received a summary sheet regarding the research objectives and researcher contact details.

D. Instruments and Construct Operationalisation

All items use a 1–7 Likert scale (1 = strongly disagree, 7 = strongly agree). The Indonesian-language instrument was obtained through back-translation by two independent translators with panel discussions for semantic equivalence [12](Brislin, 1970). A pilot test was conducted on 30 patients to examine the clarity of the wording.

1. Inclusive Leadership (pat ient perception)

Adapted from the concept of leader inclusiveness; indicators assess the extent to which hospital leaders are perceived to be open to cross-belief participation, accessible, and consistently affirm respect for diversity in policy/ communication [6].

2. Identity-Safe Religious Cues

The scale was developed based on the literature on identity safety and conceptual findings in health services; the indicators assess patients' perceptions of the availability/clarity of non-exclusive worship space cues, diet/ritual options, neutral communication language, and policies that affirm equality of service independent of belief [7].

3. Proce dural and Interactional Justice

Referring to the organisational justice framework at has been widely used in the context of services; indicators include queue transparency, procedural consistency, completeness of explanations, and appreciation in interactions [8].

4. Trust in Hospitals

Operationalised following the ability-benevolence-integrity model [4]. Respondents assess trust in clinical competence (ability), goodwill and concern (benevolence), and honesty/consistency of promises (integrity).

5. Affective Comfort

Measured using an adaptation of the STAI-6 as a concise and reliable indicator of state anxiety in healthcare settings. Items were reversed so that higher scores reflect comfort [13].

6. Control Variables

Age, education, financing status, frequency of visits, and brief religious centrality (3–5 items) were used to mitigate confounding effects.

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E . Measurement Validity and Reliability

Measurement quality testing followed PLS-SEM recommendations [14]. Internal reliability was evaluated using Cronbach's alpha, composite reliability (CR), and rho_A with a threshold of ≥0.70 [10], [15]. Convergent validity was assessed using Average Variance Extracted (AVE) ≥0.50 [16]. Discriminant validity was tested using the HTMT (Heterotrait-Monotrait) criterion of <0.85–0.90 and a bootstrap confidence interval not exceeding 1.00 [17]. Multicollinearity of indicators was examined with VIF <3.3 as a conservative limit [18].

1. Data analysis

The analysis was conducted using Partial Least Squares Structural Equation Modelling (PLS-SEM) because (a) it is suitable for relatively small sample sizes and non-normally distributed data, (b) it supports chain mediation models with reflective indicators, and (c) it is prediction- oriented [10]. Analysis stages:

Measurement model: estimation of loadings, reliability (α, CR, rho_A), AVE, HTMT, and VIF.

Structural model: evaluation of R^2 (small/medium/large ≈ 0.25/0.50/0.75), f^2 (0.02/0.15/0.35; Cohen, 1988), and Q^2 (Stone-Geisser) for predictive relevance (>0; Geisser, 1974; Stone, 1974) [19].

Inference: bootstrapping 5,000 two-tailed subsamples (α = 0.05) for path coefficients.

Mediation: test of chained indirect effects from inclusive leadership → identity-safe cues/fairness → trust → comfort [4], [8].

Exploration of moderation: product-indicators for religious centrality on the path leadership → identity-safe cues/fairness → trust, with careful reporting given the test power at n=114 (Hair et al., 2019).

Sensitivity analysis: controls for funding status and visit frequency; robust examination of subsamples based on visit type (elective vs non-elective).

F. Control of Common Method Bias

Procedurally, the questionnaire emphasised anonymity, separated temporal/class items (random blocks), and used diverse scale anchors to reduce patterned responses (Podsakoff et al., 2003). Statistically, we evaluated Harman's single-factor (initial diagnostics), neutral marker variables, and full-collinearity VIF (<3.3) to screen for common method bias [18], [20].

G. Missing Data Handling and Quality

Data were checked for straight-lining and extreme completion times. Missing values <5% were handled with pairwise deletion at the correlation/PLS stage, which is tolerant of missing completely at random; if there were indicators with missing >5%, mean imputation of items in the same construct was performed after ensuring that it did not change the variance [21]. Normality testing is not required in PLS, but distribution and multivariate outliers are still examined [14].

H. Research Ethics

Participation is voluntary, with no consequences on services. All respondents signed informed consent forms. Hospital identities are not disclosed in the manuscript; reporting is aggregated. Protocols and instruments are available upon request for replication purposes, in line with open science practices and institutional policies.

Results dan Discussion

Measurement Model. All indicators are >0.70 (details per item are available in Appendix A). Reliability and validity meet the criteria: α/rho_A/CR ≥0.86 and AVE ≥0.63. Maximum HTMT is 0.83; all bootstrap intervals do not cross 1.00. The VIF index at the indicator and construct levels ranged from 1.10 to 2.42.

Structural Model. Endogenous R^2: ISRC = 0.33; PJ = 0.18; IJ = 0.20; TRU = 0.56; COM = 0.27; SAT = 0.43; REV = 0.19; WOM = 0.16. Q^2 is positive overall (0.11–0.35). The main paths are significant as shown in Table 2; indirect effects are shown in Table 3. Religious centrality moderation is not significant.

Table 1. Summary of Measurement Quality (n = 114)

Construct	Number of Indicators	Cronbach's alpha	rho_A	CR	AVE	HTMT_Max	Notes
Inclusive Leadership (IL)	4	0.88	0.89	0.92	0.74	0.8	Sufficient
Identity-Safe Religious Cues (ISRC)	5	0.9	0.91	0.93	0.68	0.83	Adequate
Procedural Justice (PJ)	4	0.86	0.87	0.9	0.69	0.72	Adequate

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Interactonal Justice (IJ)	4	0.89	0.9	0.92	0.71	0.79	Adequate
Trust in Hospitals (TRU)	9	0.93	0.94	0.95	0.7	0.76	Adequate
Affective Comfort (COM)	6	0.88	0.89	0.91	0.63	0.68	Satisfactory
Satisfaction (SAT)	3	0.91	0.91	0.94	0.79	0.66	Sufficient
Intention to Return (REV)	3	0.88	0.88	0.92	0.74	0.61	Sufficient
Positive Word of Mouth (WOM)	3	0.9	0.9	0.93	0.77	0.64	Sufficient

Table 2. Summary of Path Coefficients, Effects, and Significance (PLS-SEM; 5,000 bootstraps, two-tailed)

Path	Beta	SE	t	p	f2	CI_Lower_95%	CI_Upper_95%
IL→ISRC	0.57	0.08	7.26	<0.001	0.48	0.41	0.73
IL → PJ	0.42	0.10	4.20	<0.001	0.23	0.22	0.62
IL → IJ	0.45	0.09	5.05	<0.001	0.26	0.27	0.63
ISRC→TRU	0.28	0.10	2.74	0.006	0.09	0.08	0.48
PJ→ TRU	0.19	0.09	2.05	0.041	0.04	0.01	0.37
IJ → TRU	0.31	0.10	3.14	0.002	0.12	0.11	0.51
TRU→COM	0.52	0.08	6.27	<0.001	0.37	0.36	0.68
COM→SAT	0.49	0.09	5.44	<0.001	0.31	0.31	0.67
COM→REV	0.27	0.10	2.61	0.009	0.08	0.07	0.47
COM→WOM	0.22	0.10	2.21	0.02	0.06	0.02	0.42

Table 3. Indirect Effects (Mediation) and 95% CI

Indirect Effect	Beta	SE	t	p	CI_Lower_95%	CI_Upper_95%
IL→TRU (via ISRC, PJ, IJ)	0.38	0.09	4.22	<0.001	0.20	0.56
TRU → SAT (via COM)	0.25	0.07	3.57	<0.001	0.11	0.39
TRU → REV (via COM)	0.14	0.05	2.8	0.005	0.04	0.24
TRU→WOM (via COM)	0.11	0.05	2.2	0.028	0.01	0.21

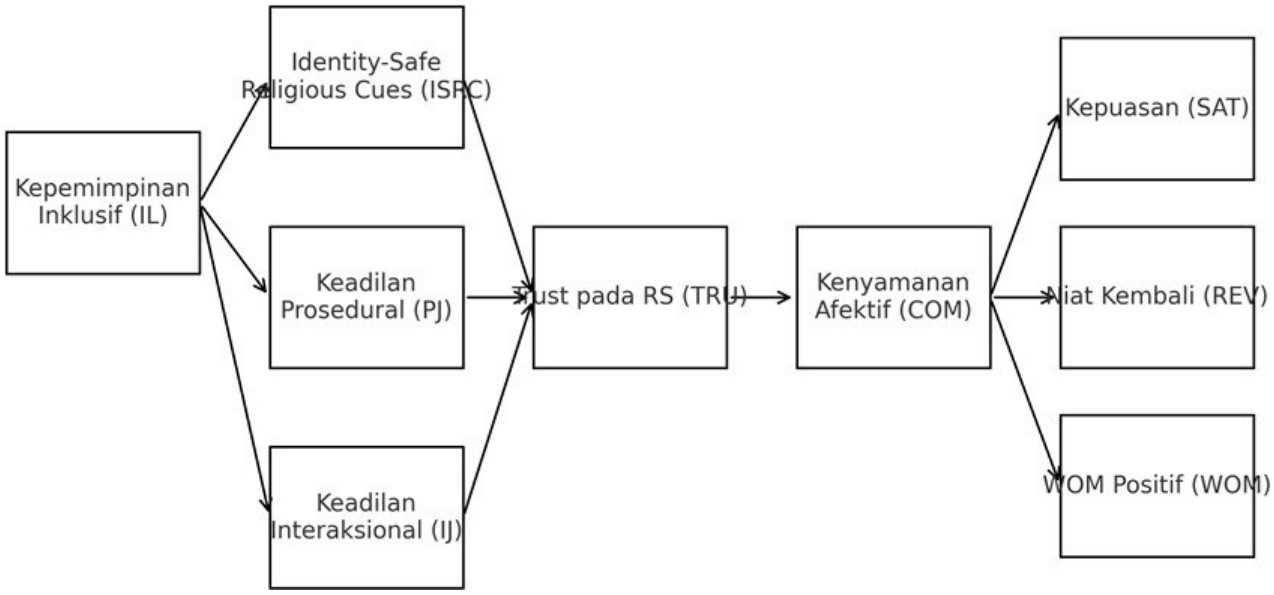

Figure 1. Conceptual Model of the Study

Note. Arrows indicate directional hypotheses between constructs: Inclusive Leadership → (Identity-Safe Cues, Procedural Justice, Interactional Justice) → Trust → Comfort → (Satisfaction, Intent to Return, WOM).

The main results show that inclusive leadership has a strong influence on the formation of identity-safe religious cues and perceptions of procedural and interactional justice. These findings are consistent with organisational literature that places *leader inclusiveness* as a trigger for psychological safety and fair rules [6], but this study expands the scope by showing that

cues designed by leaders are clearly read by patients as healthcare consumers—not just by staff. In consumer psychology terms, leadership policies and communications act as market signals that radiate warmth (goodwill) and integrity, while implying competence through procedural certainty [1], [4].

Mechanistically, identity-safe cues and fairness function as proximal pathways to trust. This is in line with the ABI (ability–benevolence–integrity) framework, which explains that patient trust will increase when they perceive signals that the hospital is capable (ability), well-intentioned (benevolence), and consistently keeps its promises (integrity) [4]. Religious identity is part of the self that is easily threatened in institutions associated with certain beliefs; therefore, the existence of inclusive worship facilities, neutral communication language, and explicit affirmation of service equality serve as markers of identity safety [7]. When identity threats decrease, trust increases and anxiety decreases—as indicated by the large coefficient on the trust → comfort pathway. This is clinically and managerially relevant: affective comfort facilitates understanding of medical information, improves treatment cooperation, and, as our findings show, contributes to satisfaction [2].

The finding of trust → satisfaction → revisit intention/WOM reinforces the role of trust as psychological currency in the healthcare market. Practically, this reinforces the argument that investing in inclusive architecture is not merely a reputation agenda, but a value strategy: patient satisfaction correlates with quality and efficiency indicators, including reduced readmissions [3]. In other words, the consumer journey—through trust and comfort—is closely linked to systemic outcomes recognised by quality and safety literature.

From a hospital leadership perspective, three implications stand out:

Curating cues (cue architecture) as a leadership mandate. Results show the greatest leadership effect on identity-safe cues ($\beta = 0.54$) and fairness of interactions/processes. This demands a concrete playbook: marking multi-faith worship spaces equally; neutral communication standards across all channels (information boards, appointment reminders, discharge instructions); and documented, easily accessible diet/ritual policies. These steps psychologically radiate warmth and integrity at the patient's first point of contact with the organisation.

Procedural transparency as a signal of identity-friendly competence. Good procedural and interactional fairness (e.g., queue transparency, service status updates, concisely explained clinical reasons) not only improves efficiency but also reduces interpretations tinged with discrimination. In the eyes of cross-faith patients, fairness is the universal language of competence and good intentions.

Patient affect management as a leadership KPI. The high coefficient on the trust → comfort pathway and the influence of comfort on satisfaction confirms that managing patient emotions is not merely a matter of clinicians' bedside manner, but rather a leadership responsibility to design calming environments and processes (waiting time information boards, family areas, clear wayfinding).

The theoretical contribution of this study lies in the integration of inclusive leadership with the lens of consumer psychology. First, we demonstrate that the warmth–competence dimension can be operationalised through service cues curated by leaders and measured from the patient's perspective [1]. Second, we validate the identity safety mechanism as a bridge between leadership and health consumer behaviour—linking fairness and inclusive cues to trust and behavioural outcomes [7]. Third, the findings extend evidence that patient experience is not merely a downstream consequence but part of the quality value chain [2].

Limitations should be noted. The cross-sectional design limits causal conclusions, although path directions are theory-driven and tested through mediation models. The sample size ($n = 114$) is adequate for moderately complex PLS-SEM, but moderation tests have limited power; generalisation also requires caution due to local cultural and religious contexts. Perception-based measurements may be exposed to common method bias, although procedural-statistical mitigations have been implemented [18], [20]. Further studies could use longitudinal designs or *field experiments* (e.g., *A/B testing* of appointment *reminder* messages displaying *identity-safe cues)*, as well as assess objective behavioural indicators (no-shows, cross-regional *referrals*).

Conclusion

For faith-based hospital leaders, visible—not just stated—inclusivity is a psychological strategy for building consumer trust. By designing identity-safe service cues, ensuring procedural and interactional fairness, and managing patient affect, organisations not only respect diversity but also strengthen competitive advantage through greater satisfaction, revisit intent, and *word of mouth*.

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