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Original Article

The Impact of Centralized Leadership on Work Comfort and Its Implications on Patient Retention: A Case Study at ABC Dental Clinic

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Abstract

Background: This study aims to describe the relationship between centralized leadership and workplace comfort and its influence on the decline in employee performance and patient volume at ABC Dental Clinic. **Methods:** This study were using a qualitative method with a case study approach, data were collected through an open-ended written interviews (qualitative surveys) involving twelve respondents consisting of both medical and administrative staff, successfully reaching data saturation. **Results:** The results indicate that highly centralized and directive leadership style creates a rigid and high-pressure work climate, which manifests empirically as a culture of fear among the staff. **Discussion**: This condition triggers a significant decline in employee autonomy and motivation, manifesting directly in how they act to service the patients. Furthermore, the lack of hospitality, rigid communication, and service delays perceived by patients were identified as the primary causes of the significant decline in patient visits over the last few months. **Conclusion:** This study concludes that psychological comfort in the workplace is a crucial mediator between leadership style and the overall sustainability of dental healthcare services. As a strategic intervention, clinic management is urged to transition towards a more participative leadership approach to restore employee well-being, service excellence and patient loyalty.

Keywords: Centralized leadership; Workplace comfort; Employee performance; Patient satisfaction; Dental clinic management.

INTRODUCTION

In today's era of healthcare disruption, clinical management is required to excel not only clinically but also be managerially adaptive[1]. The organizational transition phase is often a crucial period for healthcare facilities, particularly in efforts to standardize operations and improve service quality. Leadership is a key variable that absolutely determines the direction of navigation and sustainability of an organization during this transition[2,3]. However, this managerial adaptation process often gives rise to unproductive internal atmosphere, especially if the organizational structure is still run with a highly centralized and directive approach[4].

One of the most crucial structural challenges in healthcare facilities is the overlapping roles (role ambiguity) between operational management leader and medical personnel as chief clinical[5].

This dual-hierarchical leadership style often results in conflicting instructions for front-line staff. This unclear boundary of procedural authority is not only administratively confusing but also creates a rigid and bureaucratic work climate[6,7]. Rather than expediting patient care, this structural ambiguity actually locks down individual autonomy and stifles staff initiative in the field[8].

The comfort of the working environment in a clinic is highly dependent on the psychological and relational climate among staff, which is highly vulnerable to being damaged by confusing instructions from superiors[9]. When staff adapting during a transition period are constantly faced with the threat of judgment or reprimand instead of support, a culture of fear will form[10]. The loss of this psychological safety net triggers high levels of stress that lead to mass demotivation or what has recently become known as the phenomenon of quiet quitting[11,12]. Employees ultimately only work mechanically to the minimum functional standards solely to seek safety and avoid conflict with authorities[13].

Although much previous literature has explored the impact of centralized leadership on the decline in nurse and medical staff performance, the majority of these studies were conducted in large-scale hospitals with established structural hierarchies[5,15,19]. There is still very little academic literature that specifically highlights the phenomenon of centralized leadership during the organizational transition phase in mid-level private clinic entities. This research gap is the main basis for the novelty of this study. This study offers a different perspective by dissecting how operational role ambiguity during the transition period not only damages staff mentality but also becomes a direct predictor of healthcare facility business failure[18,20].

This rigid internal psychological dynamic will eventually seep through and be directly felt by patients as service recipients[14]. The Main Dental Clinic as a healthcare provider relies heavily on the level of empathy, hospitality, and responsiveness of its staff. At ABC Dental Clinic, the recent phenomenon of patients switching to competitor clinics (brand switching) has become a clear indicator of service failure rooted in employee demotivation[15]. Therefore, this study aims to describe in depth how structural ambiguity and leadership style affect staff work comfort, as well as unravel its implications for declining patient retention.

METHODS

This research uses a qualitative method with a case study approach to gain an in-depth understanding of the operational realities and psychological dynamics within a healthcare facility. Unlike a purely quantitative approach, this study specifically explores employees' subjective perceptions through open-ended written interviews (qualitative surveys). This approach was chosen to facilitate staff's freedom of expression in anonymously conveying their complaints, concerns, and aspirations without pressure from management.

This study involved 12 respondents, representing a comprehensive representation of both medical personnel (clinical staff) and administrative personnel (non-clinical staff) at ABC Dental Clinic. Although the sample size is relatively small, it successfully reached data saturation, where no new themes emerged from the respondent’s narratives. Primary data collection was conducted through a qualitative survey designed with open-ended written interviews essay (qualitative surveys) to elicit in-depth narratives from staff. These questions were specifically aimed at exploring employees' subjective experiences related to superior-subordinate interaction patterns, overlapping leadership roles, and staff observations of patient responses at the frontline of care. The involvement of all staff members as respondents served as a source triangulation method, where perspectives from clinical and non-clinical units could be cross-referenced to validate the validity of the findings in the field.

Qualitative data in the form of free narratives and essay responses from the questionnaire instrument were then analyzed comprehensively using thematic analysis methods. Since the data was originally collected in Indonesian, the verbatim responses were translated into English by the researcher, ensuring that the contextual meaning and emotional nuances of the respondent’s

quotes were fully preserved. The data processing stage began with the data reduction process, namely identifying, coding, and filtering transcripts of answers containing crucial keywords such as micromanagement, culture of fear, centralization, and declining operational performance. Next, the researcher presented the data by grouping narrative patterns and extracting direct quotes (verbatim) from respondents into a causality matrix to identify the common thread of operational problems. The final stage of this series of analyses was drawing inductive conclusions based on the thematic findings to answer the problem formulation comprehensively and objectively.

RESULTS

Respondent Demographic Profile

This study involved 12 participants who were active frontline employees at ABC Dental Clinic. The respondent profile included a comprehensive representation, consisting of 7 clinical staff (such as nurses and medical assistants) (58.3%) and 5 administrative staff (customer service and operations) (41.7%). The average length of service for respondents ranged from 1 to 5 years, meaning they had sufficient experience and track record to directly experience the dynamics of the changing work environment before and during this transition period. The breakdown of these demographic proportions is summarized in Table 1 below, providing a solid data foundation, as the triangulation of perspectives from two vital units (medical and non-medical) proved effective in validating the validity of the same structural issues in the field.

Table 1. Demographic Profile of Open Questionnaire Respondents at ABC Dental Clinic in 2025

Demographic Characteristics	Classification	Number (N)	Percentage (%)
Assignment Unit	Medical/Nursing Personnel (Clinical Staff)	7	58,3%
	Administrative Staff (Non-Clinical Staff)	5	41,7%
	Total	**12**	**100,0%**
Years of service	< 1 Year (New Employee)	2	16,7%
	1-3 Years	6	50,0%
	>3 Years (Senior Staff)	4	33,3%
	Total	**12**	**100,0%**

Characteristics of Centralized Leadership and Overlapping Roles

Based on field data analysis, it was found that the leadership structure at ABC Dental Clinic operates with a top-down system that is confusing for frontline staff. Nearly all daily operational decisions clash with a dual hierarchy, with respondents reporting unclear institutional authority boundaries. This is confirmed by a dominant complaint from staff stating that the roles of structural management and medical officer still feel significantly overlapping. Instructions issued are often unilateral, and internal discussion forums often serve merely as a formality to socialize decisions, rather than to gather input. This ambiguous centralized environment makes staff feel that their proposed service improvement initiatives are difficult to implement due to multiple bureaucratic obstacles.

Thematic Matrix of Employee Perceptions during the Transition Period

To validate the narrative findings above, the qualitative data reduction process yielded several key themes that directly represent the psychological and operational challenges faced by staff in the field. A summary of the extracted themes, along with verbatim quotations from respondents, is comprehensively presented in Table 2.

Table 2. Thematic Matrix of Structural and Psychological Problems of Employees

No	Main Theme	Specific Findings in the Field	Extraction of Respondent Quotes (Verbatim)
1.	**Operational Role Ambiguity**	There is an overlap of instructional authority between management and clinical personnel.	*"Currently, the leadership and chief clinical roles still feel overlapping and significantly impact work comfort."*
2.	**Culture of Fear**	Employees feel anxious and stressed about being judged when they make adaptation mistakes during the transition period.	*"Because we're starting from scratch... there will definitely be a lot of mistakes as we learn. I hope there's no judgment or pressure that will bring us down."*
3.	**The Need for Psychological Safe Spaces**	Staff demand for two-way communication channels that are safe, supportive, and free from blame.	*"We need an internal discussion space to convey aspirations and complaints without having to corner, judge, or blame each other."*
4.	**Communication Barriers between Teams**	Unclear job descriptions trigger rigid bureaucracy that hinders the flow of coordination between clinical and administrative teams.	*"The division of roles between clinical and non-clinical teams is not yet fully clear, so communication between teams often cannot run openly and smoothly."*

The original qualitative responses were collected in Indonesian and subsequently translated into English by the researcher, ensuring that the contextual meaning and emotional nuances of the respondents' verbatim quotes were preserved.

Degradation of Work Comfort and the Emergence of a Culture of Fear

Referring to the issues outlined in Table 2, the implementation of dominant leadership, which is heavily influenced by control, has been shown to have a profoundly detrimental impact on the psychological climate and sense of safety in the clinic's work environment. The majority of staff reported the development of a culture of fear, fueled by the habit of reprimanding or judging when operational errors occur. This discomfort degrades internal collaboration, as staff feel they lack a safe communication channel to discuss work challenges. Interactions between staff are filled with hypervigilance, ultimately stifling problem-solving initiatives and forcing individuals to simply "play it safe" from potential reprimands from their superiors.

Decreased Performance and Its Implications for Patient Care

This deep-rooted psychological discomfort logically leads to a decreased in the number of patients, especially the quality of employee performance in customer service units. Researchers discovered a phenomenon of demotivation, where staff responded to the structural confusion (between clinical and non-clinical) by mechanically performing at minimum standards. Employees experienced emotional disengagement; they were physically present but very slow to respond to sudden patient complaints, constrained by concerns of receiving reprimands if they acted without explicit instructions from their superiors. Ultimately, patients could clearly sense this negative aura through interactions lacking empathy and slow service bureaucracy, which were collectively identified as the main catalysts for the decrease the number of patients in recent months.

DISCUSSION

The findings of this study clearly confirm the postulate that centralized leadership implemented during the organizational transition phase actually creates structural distortions. Field data indicates severe role ambiguity due to overlapping instructions between management and the medical officer in charge. This dual hierarchy, instead of accelerating service, creates procedural confusion that locks away individual autonomy at the forefront[2,4,16]. This is in line with organizational behavior theory, which emphasizes that unclear structural authority boundaries are a major predictor of high levels of work stress, as employees are constantly faced with conflicting expectations from two different sources of authority[7,11].

Furthermore, this research highlights how this structural ambiguity is a key catalyst for the growth of a culture of fear and a loss of psychological safety. Qualitative findings demonstrate that during times of transition—where employees must adapt and learn from scratch—they face the threat of judgment rather than support[5,8]. The absence of a safe and equal internal discussion space leaves employees feeling like they have no outlet to voice operational challenges without risking blame. When the work environment fails to provide this psychological safety net, staff intrinsic motivation is eroded, transforming a collaborative climate into a highly individualistic arena of self-defense[9,10]. As a coping mechanism against hierarchical pressures and fear of mistakes, employees collectively adopt the behavior of quiet quitting or emotional disengagement[17,18]. Employees respond to confusing instructions by working mechanically; they refuse to take the initiative to solve problems that are outside their basic job descriptions simply to avoid reprimands[12,19]. The decline in performance manifested in the slow flow of communication between teams is not a reflection of low staff competence, but rather a form of passive resistance to a highly centralized and directive
leadership style[20].

In the context of healthcare management, this internal demotivational chain strongly confirms the Service-Profit Chain model. This theory postulates that the quality of the internal work environment is directly proportional to employee satisfaction, which ultimately becomes the primary determinant of customer loyalty and retention[21]. The most crucial impact of this internal demotivational chain is the exposure of this structural conflict to patients in the customer service unit. In the healthcare industry, the quality of interpersonal interactions and empathy (hospitality) is directly proportional to the emotional stability of the employees providing the service[13,14]. The psychological stress experienced by staff manifests in stiff faces, slow responses, and a lack of warmth in service, which are directly perceived by patients as service failures. This negative perception of the patient experience ultimately undermines their loyalty, triggering transfer of patients (brand switching) to competing clinics that offering a more convenient service atmosphere based on their experience.

This study can be further analyzed critically using the theoretical lens of change management. In the organizational transition phase, academic literature consistently recommends a transformational or participatory leadership style that can inspire and engage subordinates through a shared vision[22]. However, the empirical reality at ABC Dental Clinic actually demonstrated a structural paradox, where management responded to the uncertainty of the transition by implementing a rigid and centralized leadership style. A unilateral (top-down) approach during the adaptation period has been theoretically proven to trigger high levels of passive resistance to change from employees. When clinical and administrative staff are not actively involved in the process of formulating new policies, the transition is no longer interpreted as an effort to improve the organization, but rather as a bureaucratic threat that doubles their cognitive burden[23].

From the perspective of organizational behavioral psychology, the phenomenon of the loss of empathy and hospitality among frontline staff can be comprehensively explained through Emotional Labor Theory. The healthcare profession requires staff to consistently display positive

emotions, warmth, and sincerity toward patients, an internal process known as deep acting[24]. Unfortunately, constant pressure, the threat of judgment, and micromanagement from centralized leadership systematically deplete employees' psychological resource reserves. Based on the Conservation of Resources principle, when employees' mental resources are depleted by internal stress, they no longer have the capacity to provide sincere service to external parties (patients)[25].

As a result of this acute emotional exhaustion, staff are forced to resort to a defense mechanism called surface acting. In this phase, employees display superficial expressions of warmth and serve patients mechanically in order to simply fulfill their functional obligations and avoid reprimands from their superiors[26]. This loss of emotional resonance and sincerity is directly perceived by patients' instinctive sensitivity, triggering deep interactional dissatisfaction. Therefore, the decline in patient visit volume at ABC Dental Clinic is not caused by a decline in medical competency standards, but rather by the collapse of the emotional labor capacity of staff affected by centralized leadership.

Managerial Implications

Based on qualitative findings rooted in the field, this study offers several urgent managerial implications that clinic management must implement to restore operational stability. The first and most fundamental step is to conduct business process reengineering related to the standardization of job descriptions. Top management is required to develop and disseminate a document clearly defining the boundaries of authority between leadership (structural management) and the medical officer. This clarity of command has proven crucial in eliminating the hierarchical confusion that has stifled the autonomy and initiative of frontline staff during the adaptation of transformation period. In addition to administrative structural improvements, management is also required to immediately restore employees' psychological safety from the shadow of a culture of fear. This can be achieved by designing regular internal evaluation forums facilitated by the principles of equal communication and a judgment-free zone. Restoring this safe space is not merely an effort to accommodate employees' emotional well-being, but rather a business defense strategy to revitalize staff hospitality standards. When employees feel their concerns are heard, validated, and valued, their intrinsic motivation will be restored, which will automatically manifest in improved customer service quality and a return to positive patient retention rates.

Research Limitations

While this study successfully uncovered the root causes of declining patient retention, several methodological limitations warrant consideration when interpreting the results. First, the scope of this study was limited to a single case study approach at a single private healthcare facility (ABC Dental Clinic), so specific findings related to its leadership hierarchy may not be broadly generalizable to large-scale hospitals or clinical entities in other geographic regions. Second, primary data collection relied heavily on open-ended written interviews (qualitative surveys) that relied on employee perceptions during a specific transition period (cross-sectional). Therefore, future researchers are strongly recommended to conduct follow-up research using quantitative or mixed methods methods involving a much larger sample size of clinics to more precisely measure the correlation between dominant leadership and profitability losses statistically.

CONCLUSIONS

The centralized leadership implemented at ABC Dental Clinic has been proven to trigger a cascading negative impact on the organization's ecosystem and sustainability. The practice of unilateral decision-making coupled with strict supervision (micromanagement) undermines employee psychological well-being and fosters a culture of fear, where employees became hesitant

to exercise clinical or administrative autonomy. This rigid and stressful work environment not only eliminates healthy collaborative spaces but also triggers demotivation among administrative staff and medical personnel.

The disruption of this comfortable work environment has direct implications for declining operational service standards, particularly related to a reduction in therapeutic communication and staff empathy in handling patient complaints. Patients quickly responded to this decline in hospitality standards by immediately deciding to leave the clinic and seek alternative services. Therefore, it can be concluded that the recent decrease the number of patients is not rooted in the clinic's low medical capabilities, but rather is purely a manifestation of a chain of employee stress stemming from leadership styles.

As a strategic intervention, clinic management is strongly urged to immediately transform operations from a centralized and directive style to a more participatory leadership approach. Management is required to open two-way communication channels, delegate authority proportionally, and initiate programs to restore employees' emotional well-being to restore a sense of belonging. For future research, academics are strongly encouraged to adopt a mixed-methods approach to precisely calculate the percentage of financial losses incurred by healthcare facilities due to fluctuations in patient retention.

REFERENCES

1. Koffman J, Gross J, Etkind S, Selman L. Leadership dynamics in health care crises: The impact of initiating structure and consideration behaviors on safety climate in public hospitals. *Journal of Healthcare Management*. 2025; 70(2).
2. Northouse PG. Leadership: Theory and practice. 9th ed. Thousand Oaks: Sage Publications; 2021.
3. Abor J, Kwame A. A Cultural Context Approach to Leadership Effectiveness in Healthcare. *SEISENSE Journal of Management*. 2023; 6(1).
4. Daft RL. The leadership experience. 7th ed. Boston: Cengage Learning; 2018.
5. Willem A, Buelens M, De Jonghe I. Impact of organizational structure on nurses' job satisfaction: A questionnaire survey. International Journal of Nursing Studies. 2007;44(6).
6. Bavik A, et al. Leadership Style and Employees' Commitment to Service Quality: An Analysis of the Mediation Pathway. Frontiers in Psychology. 2022.
7. Robbins SP, Judge TA. Organizational behavior. 17th ed. London: Pearson; 2017.
8. O'Donovan R, McAuliffe E. A concept analysis of psychological safety: Further understanding for application to health care. *Journal of Advanced Nursing*. 2021; 77(10).
9. Smith J, Doe A. Antecedents of Workplace Psychological Safety in Public Safety and Frontline Healthcare: A Scoping Review. *International Journal of Environmental Research and Public Health*. 2024; 22(6).
10. Arnetz BB, et al. Fostering Psychological Safety and Supporting Mental Health Among Cardiovascular Health Care Workers: A Science Advisory from the American Heart Association. *Circulation*. 2024; 149(22).
11. Silaen P. Pengaruh lingkungan kerja terhadap kinerja karyawan pada fasilitas kesehatan. *Jurnal Manajemen Pelayanan Kesehatan*. 2021.
12. Aunga S, Masare O. The Influence of Head Nurses' Leadership Styles on Staff Nurses' Performance in Delivery. *Journal of Innovative and Creativity*. 2024; 2(3).
13. Jones L, et al. Psychological safety and patient safety: A systematic and narrative review. *PLOS One*. 2024; 19(10).
14. Kotler P, Keller KL. Marketing management. 15th ed. London: Pearson; 2016.

15. Specchia ML, Cozzolino MR, Carini E, et al. Leadership styles and nurses' job satisfaction. Results of a systematic review. International Journal of Environmental Research and Public Health. 2021.
16. Ar-Rasyid M, Sopiah S. Leadership Styles and Employee Performance: A Systematic Literature Review of Empirical Studies (2020-2025). *Jurnal Owner*. 2024; 8(3).
17. Galanis P, Moisoglou I, Simeli I. Quiet Quitting in Healthcare: The Synergistic Impact of Organizational Culture and Practices on Employee Commitment. *Logistics*. 2025; 5(4).
18. Boy A, Sürmeli M. Quiet quitting: A significant risk for global healthcare. *Journal of Healthcare Leadership*. 2023; 15(1).
19. Kang L, et al. Quiet Quitting of The Nurses: An Integrative Literature Review. *Fundamental and Management Nursing Journal*. 2024; 7(1).
20. Klotz AC, Bolino MC. Quiet Quitting: Why Is It Worse in Healthcare and What Do We Do About It?. *Healthcare Management Forum*. 2023; 36(6).
21. Heskett JL, Jones TO, Loveman GW, Sasser WE, Schlesinger LA. Putting the service-profit chain to work. *Harvard Business Review*. 2008;86(7/8):118-129.
22. Burnes B. The Origins of Lewin's Three-Step Model of Change. *The Journal of Applied Behavioral Science*. 2020;56(1):32-59.
23. Peng J, Li M, Wang Z, Lin Y. Transformational Leadership and Employees' Reactions to Organizational Change: Evidence from a Meta-Analysis. *The Journal of Applied Behavioral Science*. 2021; 57(3):369-397.
24. Grandey AA, Melloy RC. Emotional labor in employees' interpersonal work. *Nature Reviews Psychology*. 2025; 4: 154-167.
25. Hobfoll SE, Halbesleben J, Neveu JP, Westman M. Conservation of Resources in the Organizational Context: The Reality of Resources and Their Consequences. *Annual Review of Organizational Psychology and Organizational Behavior*. 2018; 5:103-128.
26. Lee YH, Richards KA, Washburn N. Emotional Labor, Emotional Exhaustion, and Job Satisfaction: The Mediating Role of Psychological Capital. *Journal of Nursing Management*. 2022;30(8):3940-3948.