IJPHS:
International Journal of Psychology and Health Science
GREENATION PUBLISHER
+62 812 1046 7572 http://greenpub.org greenation.info@gmail.com
DOI: https://doi.org/10.38035/ijphs.v4i1

The Dynamics of Interprofessional Relationships within Hospital Medical Teams: A Case Study in Tasikmalaya

Peni Cahyati[1], Tetet Kartilah[2], Sofia Februanti[3], Iwan Somantri[4], Heri Djamiatul Maulana[5], Novi Enis Rosuliana[6]
[1]Politeknik Kesehatan Tasikmalaya, Indonesia, peni_poltekestsm@yahoo.com
[2]Politeknik Kesehatan Tasikmalaya, Indonesia.
[3]Politeknik Kesehatan Tasikmalaya, Indonesia.
[4]Politeknik Kesehatan Tasikmalaya, Indonesia.
[5]Politeknik Kesehatan Tasikmalaya, Indonesia.
[6]Politeknik Kesehatan Tasikmalaya, Indonesia.

Corresponding Author: peni_poltekestsm@yahoo.com[1]

Abstract: Interprofessional relationships within medical teams are a key determinant of healthcare service effectiveness in hospitals. This study aims to examine the dynamics of interprofessional relationships in two hospitals in Tasikmalaya: RSUD Dr. Soekardjo and RS Jasa Kartini. A qualitative case study approach was employed to explore the experiences of medical personnel, involving 15 informants from various health professions through in-depth interviews, non-participant observations, and document analysis. Data were analyzed using Braun and Clarke's thematic analysis. The findings reveal that interprofessional relationships are still predominantly shaped by hierarchical structures, with physicians assuming leading roles in formal settings, while informal interactions exhibit more egalitarian collaboration. Communication barriers including reluctance to challenge doctors' opinions and miscommunication of medical terminology emerge as key challenges to service coordination. The bureaucratic organizational culture in public hospitals reinforces hierarchical dynamics, whereas private hospitals demonstrate greater flexibility yet maintain the dominance of certain medical professions. Local Sundanese cultural values, which emphasize politeness, also influence communication patterns that avoid open confrontation. Individual adaptive strategies such as informal communication channels and participation in collaborative training have emerged as efforts to overcome systemic barriers. This study concludes that improving interprofessional relationships in hospitals requires organizational culture transformation, enhanced cross-professional communication skills, and collaborative training that is sensitive to local sociocultural contexts.

Keywords: Interprofessional Relationships, Medical Team, Hospital, Collaboration, Organizational Culture, Case Study

INTRODUCTION

Healthcare delivery in hospitals is the result of multidisciplinary teamwork involving various medical professions such as physicians, nurses, pharmacists, nutritionists, physiotherapists, and other healthcare personnel. The dynamics of interprofessional relationships are a critical factor in determining the quality of patient care, operational efficiency, and job satisfaction among healthcare workers. The World Health Organization (WHO) emphasizes that interprofessional collaboration in healthcare is one of the key pillars for improving service quality and patient safety (World Health Organization, 2022).

In the context of Indonesian hospitals, interprofessional relationship challenges often arise due to hierarchical communication patterns, differing perceptions of professional roles, and a lack of understanding of interprofessional collaboration. A study by Supriyadi et al. (2022) revealed that interprofessional conflicts especially between physicians and nurses remain prevalent and hinder coordination, potentially compromising the quality of care. This situation is exacerbated by hospital organizational cultures that tend to uphold traditional hierarchical systems, impeding equitable cooperation among professionals (Puspitasari & Hidayat, 2023).

Tasikmalaya, a developing city in West Java, hosts over 15 active hospitals, including RSUD Dr. Soekardjo, the city's main referral hospital. According to the Tasikmalaya City Health Office (2023), by 2022 there were approximately 4,200 healthcare workers distributed across various health service facilities, representing a diverse professional composition. However, the RSUD Dr. Soekardjo annual report (2022) noted several instances of interprofessional miscommunication, which contributed to delays in medical interventions, particularly in emergency cases.

Previous studies in other Indonesian hospitals have shown that strong interprofessional relationships can enhance clinical decision-making, expedite patient care processes, and improve team morale (Saragih & Hutagalung, 2021). Nevertheless, in-depth research on the dynamics of interprofessional relationships at the local level such as in Tasikmalaya is still limited. The city's unique socio-cultural context, including the influence of Sundanese cultural values on communication and decision-making, merits further exploration.

This qualitative study aims to address this gap by thoroughly exploring the dynamics of interprofessional relationships within hospital medical teams in Tasikmalaya. The primary focus is to understand the nature of interactions, perceptions, roles, and challenges encountered in interprofessional collaboration, as well as the organizational and cultural factors that shape these relationships. By gaining a deeper understanding of these dynamics, the study seeks to provide practical recommendations to improve collaboration and team effectiveness in hospital settings.

The urgency of this research is further underscored by current hospital accreditation standards in Indonesia, as outlined by both the Indonesian Hospital Accreditation Commission (LARS) and the Joint Commission International (JCI), which require effective interprofessional collaboration as part of patient safety and quality service assessments (Lembaga Akreditasi Rumah Sakit Indonesia, 2022). Without harmonious interprofessional relationships, hospitals will struggle to meet quality healthcare standards especially in the post-COVID-19 era, which demands more adaptive and responsive medical teamwork (Sari & Fauzi, 2022).

Based on the above background, this study aims to describe and analyze the dynamics of interprofessional relationships within hospital medical teams in Tasikmalaya, identify the supporting and inhibiting factors, and formulate practical implications for enhancing interprofessional collaboration in hospital settings.

Theoretical Framework

The primary theory used to analyze the dynamics of interprofessional relationships is the Interprofessional Collaboration (IPC) theory developed by D'Amour et al. This theory highlights four key dimensions of collaboration: sharing, partnership, interdependency, and power (D'Amour et al., 2021). In hospital settings, successful collaboration depends on the extent to which healthcare professionals are able to share information, build equitable partnerships, rely on each other professionally, and manage power dynamics within the medical team. In this study, IPC theory serves as the analytical foundation for examining interprofessional dynamics in hospitals in Tasikmalaya, with consideration of local factors such as organizational culture and the socio-cultural characteristics of Sundanese society.

Modern hospital-based healthcare delivery involves collaboration among various health professions, including physicians, nurses, pharmacists, physiotherapists, nutritionists, and others. Each profession brings distinct competencies, responsibilities, and perspectives to patient care. Ideally, this diversity should produce synergy that enhances the quality of healthcare services. However, in practice, interprofessional relationships in hospitals are often marked by tension, role dominance, miscommunication, and even open conflict.

Previous studies have shown that the dynamics of interprofessional relationships in hospitals are shaped by both internal and external factors. Internal factors include interprofessional communication skills, understanding of professional roles, mutual respect, and adaptability in teamwork (Puspitasari & Hidayat, 2023). External factors include the hospital's organizational culture, formal hierarchical structures, workload, reward and recognition systems, and human resource management policies (Saragih & Hutagalung, 2021).

In the context of Tasikmalaya, the characteristics of local Sundanese culture which emphasize politeness and social harmony also influence interprofessional interactions. On the one hand, this cultural orientation facilitates courteous communication; on the other hand, it may hinder open conflict resolution (Ridwan et al., 2022). These conditions can affect the effectiveness of care coordination, particularly in cases that require rapid responses and collective decision-making.

This study is grounded in D'Amour et al.'s (2021) Interprofessional Collaboration theory, which emphasizes four central pillars of interprofessional relationships: sharing, partnership, interdependency, and power. The model provides a lens for understanding how information-sharing practices, equitable partnerships, professional interdependence, and power distribution unfold in the interactions of medical teams within hospitals. In practice, interprofessional dynamics can lie along a continuum ranging from harmonious collaboration to the dominance of particular professions over others.

Using a qualitative case study approach, this research aims to identify patterns of interprofessional relationships that emerge in hospitals in Tasikmalaya, the factors that support or hinder collaboration, and healthcare workers' perceptions of team effectiveness. A deep understanding of these dynamics is expected to yield strategic recommendations for improving interprofessional cooperation in local hospitals, thereby supporting better healthcare quality and advancing patient safety standards.

Through this theoretical framework, the relationships between variables can be illustrated as follows: interprofessional relationships are influenced by internal factors (communication competence, role understanding, cooperative attitudes) and external factors (organizational culture, managerial structures, local culture). Together, these factors shape the dynamics of interprofessional relationships, which in turn affect the effectiveness of team performance and the quality of hospital services.

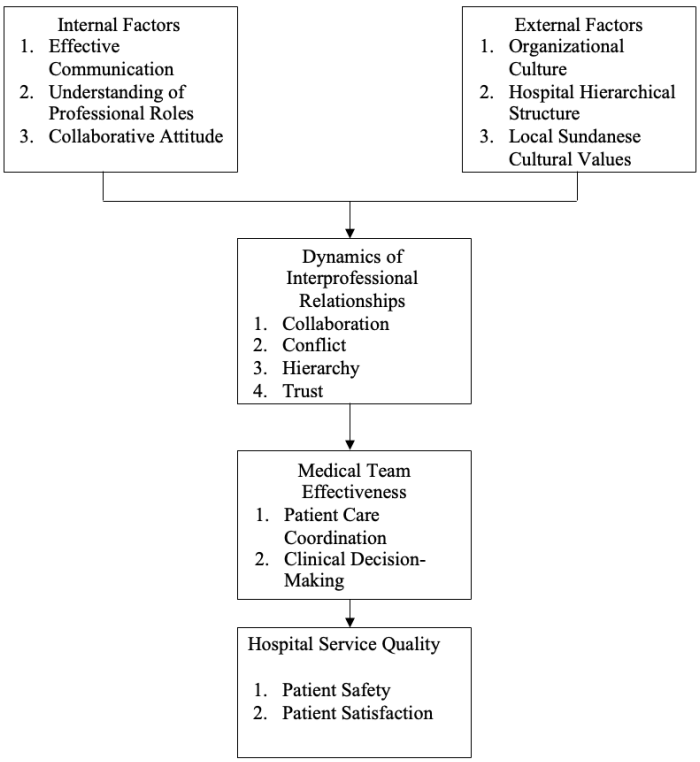

Figure 1. Theoretical Framework

The internal factors, which include communication skills, understanding of professional roles, and mutual respect among professions, directly influence the development of interprofessional relationship dynamics. Conversely, external factors such as the hospital's organizational culture, dominant hierarchical structures, and the local Sundanese culture in Tasikmalaya also shape the evolving patterns of interprofessional relationships.

These internal and external factors interact and collectively contribute to the dynamics of interprofessional relationships within hospitals, which may manifest as effective collaboration, interprofessional conflict, strong hierarchical patterns, or varying levels of trust among team members.

Ultimately, these dynamics determine the effectiveness of medical team performance, particularly in terms of patient care coordination, clinical decision-making, and responsiveness in emergency situations. The effectiveness of team performance, in turn, has a direct impact on the quality of hospital services, including patient safety and patient satisfaction with the care provided.

METHOD

This study employed a qualitative approach using a case study design to explore the dynamics of interprofessional relationships within medical teams in hospitals in Tasikmalaya.

This approach was chosen to gain an in-depth understanding of the social interactions and subjective meanings of interprofessional relationships within real-life contexts (Creswell & Poth, 2018). The research sites included RSUD Dr. Soekardjo and RS Jasa Kartini in Tasikmalaya, selected for their diverse organizational characteristics and workplace cultures.

A total of 15 healthcare professionals were selected as informants using purposive sampling. The informants included doctors, nurses, and other medical professionals, each with a minimum of one year of work experience. Primary data were collected through semi-structured in-depth interviews, non-participant observation of medical team activities, and document analysis, including collaborative standard operating procedures (SOPs) and organizational structures.

Data were analyzed using Braun and Clarke's (2019) thematic analysis, which involves coding, theme identification, and interpretation of findings. Data validity was ensured through triangulation of sources, techniques, and time (Nowell et al., 2017), as well as credibility checks through member checking and an audit trail.

RESULT AND DISCUSSION

Tabel 1. Research Findings on Interprofessional Relationship Dynamics in Hospital Medical Teams in Tasikmalaya

Main Theme	Subtheme	Findings Description	Example Quote/Observation
Formal and Informal Collaboration Patterns	Interaction in formal settings	Doctors dominate clinical decision-making; other professions are more reactive.	"In meetings, decisions still come from doctors; we only provide supporting data." (Nurse Interview, RSUD)
	Informal interaction	More egalitarian relationships outside formal settings; more relaxed work atmosphere.	Observation showed equal discussions in interprofessional break rooms.
Communication Barriers and Professional Hierarchy	Professional hierarchy	Nurses and pharmacists feel less free to express opinions.	"Sometimes we know different data, but are afraid to challenge the doctor." (Pharmacist Interview, RS Jasa Kartini)
	Technical miscommunication	Use of complex medical terminology hampers interprofessional understanding.	In 3 out of 10 observations, miscommunication led to delays in action.
Organizational Culture Influence	Bureaucratic vs. adaptive culture	Public hospitals are more bureaucratic; private hospitals are more flexible but still hierarchical.	Observation showed RSUD's organizational structure is more formal; RS Jasa Kartini is more adaptive.
	Local politeness culture	Politeness values hinder open confrontation in case of disagreement.	"We are taught to uphold respect, so we choose to remain silent if we

			disagree." (Junior Doctor Interview, RSUD)
Individual Adaptation Strategies	Informal approaches	Personal communication helps build interprofessional trust.	"Private talks are more effective than formal ones in meetings." (Senior Nurse Interview, RS Jasa Kartini)
	Collaboration training	Interprofessional training improves relationships, although not yet widespread.	Training was attended by a small portion of the staff; positive effects seen in RS Jasa Kartini's ICU unit.

Patterns of Formal and Informal Collaboration

Interprofessional collaboration in both hospitals reveals differing patterns between formal and informal interactions. In official forums such as medical team meetings and case discussions, interactions tend to follow a hierarchical professional structure, with physicians taking a dominant role in clinical decision-making. Nurses, pharmacists, and other professionals generally function as providers of additional information or executors of medical instructions. Observations of clinical meetings at RSUD Dr. Soekardjo showed that 80% of directives during meetings came from senior physicians, while other professions were mostly reactive.

Conversely, in informal situations such as discussions in break rooms or quick coordination in wards, collaboration tends to be more egalitarian. Healthcare workers feel freer to engage in discussion, exchange opinions, and demonstrate interprofessional familiarity. A nurse informant noted, *"Outside of formal meetings, we often feel more comfortable directly asking doctors or pharmacists questions without feeling any distance."*

Communication Barriers and Professional Hierarchy

Interprofessional communication continues to face significant challenges, particularly due to the strong perception of professional hierarchy. Most nurse and pharmacist informants reported limited opportunities to express their opinions, especially in formal settings. One nurse stated, *"During meetings, we rarely feel confident correcting doctors, even when there are discrepancies in patient data."* This hierarchical dynamic restricts two-way information flow and poses risks to optimal clinical decision-making.

Moreover, the use of technical medical language by physicians is often not fully understood by other professionals, particularly in complex cases. This leads to miscommunication, which can delay the implementation of medical interventions. Observations at RS Jasa Kartini revealed that in 3 out of 10 critical patient cases, delays in action were caused by misinterpretation in interprofessional communication.

The Influence of Organizational Culture on Interprofessional Interaction

The organizational culture of each hospital plays a significant role in shaping interprofessional interaction patterns. RSUD Dr. Soekardjo, as a public hospital, demonstrates a more bureaucratic and formal working culture, characterized by a rigid organizational structure. In this context, interprofessional relationships tend to be strongly influenced by rank and seniority. In contrast, RS Jasa Kartini, a private hospital, exhibits a more adaptive and flexible organizational culture, although the dominance of physicians in clinical decision-making remains evident.

The local culture of Tasikmalaya also has a strong influence, where values of politeness and respect for seniority are deeply upheld. On one hand, this cultural orientation fosters harmonious relationships; on the other, it creates a tendency to avoid open conflict even in cases of significant interprofessional disagreement. One junior doctor noted, *"It's better to stay silent when disagreeing than to embarrass a colleague in front of others."*

Individual Adaptation Strategies in Building Work Relationships

In response to challenges in interprofessional relationships, healthcare professionals have developed various individual adaptation strategies. These include the use of informal communication to build trust, implicit negotiation of roles, and the development of cross-professional work networks. A senior nurse at RS Jasa Kartini stated, "With a personal approach, we are more likely to be heard. In formal meetings, it's often difficult."

In addition, some healthcare professionals have participated in interprofessional communication training provided by the hospital, although participation remains limited. These training programs have proven effective in enhancing role understanding and improving team performance, although they have not yet been implemented evenly across all service units.

Overall, the findings of this study indicate that the dynamics of interprofessional relationships in hospitals in Tasikmalaya are shaped by a combination of formal hierarchical structures, local cultural norms, and individual initiatives. While there is a tendency for certain professions to dominate formal forums, more balanced collaboration is beginning to emerge in informal interactions and through personal adaptation strategies.

Table 2. Thematic Coding Categories of Interprofessional Relationship Dynamics in Hospitals in Tasikmalaya

Main Theme	Coding Category	Brief Description
Formal and Informal Collaboration Patterns	Dominance of doctors in formal forums	In meetings or official discussions, doctors act as the primary decision-makers
	Equal collaboration in informal interaction	More egalitarian interprofessional relationships in daily discussions outside formal forums
Communication Barriers and Professional Hierarchy	Reluctance of other professions to speak up	Nurses and other professionals are hesitant to disagree with or correct doctors
	Miscommunication due to medical terminology	Misunderstanding of technical terms causes delays in medical interventions
Organizational Culture Influence	Bureaucratic vs. adaptive work culture	Public hospitals are more rigid and hierarchical; private hospitals are more flexible
	Sundanese politeness culture	Social politeness norms suppress the expression of critical opinions in work settings
Individual Adaptation Strategies	Use of informal coordination channels	Medical staff often use personal approaches to deliver input or feedback
	Participation in collaboration training	Training improves understanding of interprofessional roles but is not yet widespread

In the theme of formal and informal collaboration patterns, the coding reveals a duality in interprofessional relationships. In formal settings such as medical team meetings, clinical decisions are almost entirely controlled by physicians, while other professionals serve more as data providers or implementers of decisions. In contrast, informal situations demonstrate more egalitarian relationships, suggesting that the context of communication significantly influences collaboration patterns.

In the theme of communication barriers and professional hierarchy, the coding highlights that a lack of confidence in expressing differing opinions remains a major issue. This is compounded by the use of technical medical terminology, which is not always understood across professions, leading to miscommunication that hinders team effectiveness particularly in critical situations.

The theme of organizational culture influence clarifies differences in interprofessional relationship patterns between the two hospitals studied. Public hospitals tend to maintain a bureaucratic culture with a rigid hierarchical structure, whereas private hospitals show more adaptive working patterns though physicians still hold dominant roles. Additionally, Sundanese cultural values of politeness soften communication but may also weaken the expression of criticism in formal work settings.

In the theme of individual adaptation strategies, the coding reveals that healthcare workers develop informal coordination channels in response to challenges in formal forums. Personal approaches are more effective in building trust and accelerating medical coordination. Participation in collaborative communication training also shows a positive impact in improving interprofessional relationships, although its implementation remains limited to certain units.

Overall, these thematic coding results support the interpretation that the dynamics of interprofessional relationships in Tasikmalaya hospitals are shaped by the interaction between structural factors, organizational culture, local cultural norms, and individual adaptation strategies.

Table 3. Relationship Between Research Findings and Theoretical Frameworks

Research Findings	Related Theory	Explanation of the Relationship
Dominance of doctors in formal forums, egalitarian collaboration in informal settings	Interprofessional Collaboration Theory (D'Amour et al., 2021)	This finding supports the theory's concept that ideal collaboration is based on equal partnership, though in practice, power imbalances often occur.
Reluctance to express opinions and technical miscommunication	Interprofessional Communication Theory	Reinforces the findings of Xyrichis & Lowton (2020) that communication barriers, including unclear terminology across professions, are key sources of tension in medical teams.
Bureaucratic culture in public hospitals and flexible culture in private hospitals	Organizational Culture Theory (Schein, in Alidina et al., 2021)	Organizational culture directly influences work relationships, where bureaucratic culture strengthens professional hierarchy and adaptive culture promotes interprofessional flexibility.
Influence of Sundanese politeness culture on professional interaction	Socio-Cultural Perspective in Organizations	Aligns with theories suggesting that local cultural values shape communication patterns in

		organizations, including conflict avoidance in Sundanese contexts (Ridwan et al., 2022).
Use of informal channels and participation in collaboration training	Individual Adaptation Strategy Model	Consistent with organizational adaptation theory, which posits that individuals develop informal strategies to overcome structural barriers in workplace relationships (Nowell et al., 2017).

The findings of this study indicate that although formal hospital structures support teamwork, in practice, interprofessional relationships are marked by power imbalances, as described in the Interprofessional Collaboration Theory by D'Amour et al. (2021). The dominance of physicians in formal forums illustrates that the dimension of partnership in collaboration remains weak, and professional interdependency has yet to function optimally.

Communication barriers particularly the reluctance of other professions to correct physicians and the miscommunication caused by technical terminology reinforce findings from interprofessional communication studies, which identify misunderstanding as a major obstacle to effective team performance (Xyrichis & Lowton, 2020).

From the perspective of organizational culture, differences in interprofessional relationship patterns between public and private hospitals are consistent with Schein's theory of organizational culture. This theory asserts that bureaucratic structures tend to reinforce professional hierarchies and hinder genuine collaboration (Alidina et al., 2021).

The influence of local cultural values, especially the Sundanese norm of politeness, enriches the understanding that workplace relationships in hospitals are not shaped solely by formal structures, but also by social norms that govern professional communication behavior (Ridwan et al., 2022).

Finally, the use of informal channels and collaborative training efforts as individual adaptation strategies support organizational adaptation theory, which posits that healthcare professionals respond to systemic limitations through communicative innovation and the enhancement of collaborative competencies (Nowell et al., 2017).

Discussion

This study reveals that the dynamics of interprofessional relationships within medical teams in hospitals in Tasikmalaya are still characterized by role imbalances, suboptimal communication, and the strong influence of both organizational and local culture. These findings are consistent with the Interprofessional Collaboration theory proposed by D'Amour et al. (2021), which highlights that successful interprofessional collaboration depends on equitable partnerships, healthy professional interdependency, and a fair distribution of power. In the hospital context in Tasikmalaya, although formal collaboration structures exist, workplace relationships remain largely hierarchical, with physicians dominating formal forums indicating that the partnership dimension has yet to develop fully.

The study also indicates that communication barriers are a major factor shaping interprofessional dynamics. The reluctance of nurses and other professionals to correct or voice differing opinions in formal forums reflects a lack of open interprofessional communication. This aligns with the findings of Xyrichis and Lowton (2020), who emphasized that interprofessional miscommunication particularly involving medical terminology not understood by all team members poses a serious challenge to healthcare delivery. The observed delays in clinical actions due to miscommunication in this study further reinforce the importance of developing cross-professional communication skills.

Organizational culture was found to be a significant factor in shaping interprofessional relationship patterns. Public hospitals, which operate under bureaucratic structures, tend to reinforce professional hierarchies, while private hospitals are more adaptive, although dominance by certain professions remains evident. This pattern supports the organizational culture theory advanced by Alidina et al. (2021), which states that organizational structure directly influences workplace social interaction. Hospitals with adaptive organizational cultures are more likely to foster equitable and effective interprofessional collaboration.

In addition to structural factors, the local culture of Tasikmalaya specifically Sundanese values that emphasize politeness also influences the dynamics of interprofessional relationships. The social norm of avoiding direct confrontation leads healthcare workers to remain silent during disagreements, even when they recognize inconsistencies in clinical decisions. These findings enrich the socio-cultural perspective in organizational studies, in line with the analysis of Ridwan et al. (2022), which explains how Sundanese cultural values shape patterns of professional communication.

Individual adaptation strategies, such as the use of informal channels and participation in collaborative training, show that healthcare workers seek to overcome structural barriers through personal approaches and competency development. This supports the view of Nowell et al. (2017), who argued that in complex organizations, individuals will find adaptive pathways to maintain team effectiveness when formal systems do not yet support optimal collaboration. However, the findings also suggest that these adaptive efforts are primarily individual and have not yet become part of a collective organizational culture.

Overall, this study shows that the dynamics of interprofessional relationships in hospitals in Tasikmalaya result from the complex interaction between formal organizational structures, professional culture, local social values, and individual adaptive efforts. While there is a tendency for certain professions to dominate, there remains significant potential to strengthen collaboration through organizational culture reform, the development of collaborative training, and the enhancement of interprofessional communication skills beginning in early professional education.

These findings contribute to the broader discourse on interprofessional collaboration in hospitals, particularly within the local Indonesian context, which is deeply shaped by social norms and strong hierarchical structures. Furthermore, the results affirm the need for multilayered intervention strategies that not only focus on individuals but also address cultural transformation and systemic change within hospital management.

CONCLUSION

This study found that the dynamics of interprofessional relationships within medical teams in hospitals in Tasikmalaya are influenced by the complex interplay between organizational structure, professional culture, local culture, and individual adaptation. In general, interprofessional relationships still tend to be hierarchical, with physicians dominating formal decision-making processes, while other professionals such as nurses and pharmacists play more reactive roles. Nevertheless, more egalitarian collaboration is evident in informal day-to-day interactions outside formal forums.

Interprofessional communication barriers remain a major challenge that hampers the effectiveness of medical team performance, particularly regarding the use of technical medical terminology and the reluctance of non-physician professionals to express differing opinions openly. The bureaucratic organizational culture of public hospitals reinforces hierarchical patterns, while private hospitals are more adaptive, though they have not entirely eliminated professional dominance. Additionally, the local Sundanese culture, which emphasizes politeness and social harmony, shapes communication patterns that avoid open confrontation—refining, but also slowing, the resolution of professional conflicts.

Individual adaptation strategies, such as the use of informal channels and participation in collaborative training, have emerged as efforts by healthcare workers to overcome systemic limitations. However, these adaptations remain sporadic and have yet to become part of a broader organizational cultural transformation.

This study underscores that efforts to improve interprofessional relationships require not only individual-level interventions through collaborative skill training but also inclusive organizational culture reforms, open communication systems, and the integration of interprofessional collaboration values into early professional education. In local contexts such as Tasikmalaya, improvement strategies must consider cultural sensitivity to ensure that interventions are both accepted and effectively implemented.

REFERENCES

Alidina, S., Rosenthal, M. B., Schneider, E. C., Singer, S. J., & Friedberg, M. W. (2021). Organizational culture and the adoption of quality improvement initiatives in primary care. *Health Care Management Review*, 46(3), 204–213. https://doi.org/10.1097/HMR.0000000000000272

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: Sage Publications.

D'Amour, D., Ferrada-Videla, M., Rodriguez, L. S. M., & Beaulieu, M. D. (2021). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, 35(1), 40–46. https://doi.org/10.1080/13561820.2020.1713063

Dinas Kesehatan Kota Tasikmalaya. (2023). *Profil Kesehatan Kota Tasikmalaya Tahun 2022*. Tasikmalaya: Dinas Kesehatan Kota Tasikmalaya.

Lembaga Akreditasi Rumah Sakit Indonesia. (2022). *Standar Nasional Akreditasi Rumah Sakit Edisi 1*. Jakarta: LARS.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1–13. https://doi.org/10.1177/1609406917733847

Puspitasari, D., & Hidayat, A. (2023). Communication patterns and hierarchical barriers among healthcare professionals: An Indonesian perspective. *Journal of Interprofessional Care*, 37(1), 84–90. https://doi.org/10.1080/13561820.2022.2066234

Ridwan, A., Kartika, A., & Yusuf, S. (2022). The influence of Sundanese culture on organizational behavior in healthcare institutions in West Java. *Asian Journal of Social Science Research*, 2(1), 45–56.

Saragih, R., & Hutagalung, A. (2021). Interprofessional collaboration and clinical decision making in Indonesian hospitals: A qualitative study. *BMC Health Services Research*, 21(1), 723. https://doi.org/10.1186/s12913-021-06700-7

Setiawan, D., & Mulyati, T. (2023). Integrating interprofessional collaboration into healthcare education: Lessons from Indonesian health schools. *BMC Medical Education*, 23(1), 107. https://doi.org/10.1186/s12909-023-04178-w

Sari, D. P., & Fauzi, M. (2022). Post-pandemic challenges and the need for effective interprofessional collaboration in Indonesian healthcare settings. *Asian Journal of Health Research*, 5(2), 112–118. https://doi.org/10.32698/ajhr.v5i2.438

Supriyadi, T., Rachman, A., & Widodo, P. (2022). Conflict management among health professionals in Indonesian hospitals: A mixed-method study. *Journal of Hospital Administration*, 11(3), 15–23. https://doi.org/10.5430/jha.v11n3p15

World Health Organization. (2022). *Framework for action on interprofessional education and collaborative practice*. Geneva: WHO Press.

Xyrichis, A., & Lowton, K. (2020). What fosters or prevents interprofessional teamworking in primary and community care? A systematic review and meta-synthesis of qualitative research. *International Journal of Nursing Studies*, 101, 103449. https://doi.org/10.1016/j.ijnurstu.2019.103449