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# Investigating the Role of Health Communication in Improving the Organizational Performance of Healthcare Centers: Public and Private Clinics

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## ABSTRACT

The purpose of this study was to investigate the role of health communication in predicting the organizational performance of employees in private and public clinics. Given that the quality of employees' communication with patients and with each other can affect organizational efficiency and effectiveness, this study specifically addressed the various dimensions of health communication, including conscious initiation, verbal and non-verbal skills, unconditional acceptance of the client, and the total score of health communication. The present research was a descriptive-correlational study. The statistical population consisted of employees from private and public clinics, who possessed diverse demographic characteristics in terms of gender, age, and work experience. The Organizational Performance Questionnaire and the Health Communication Questionnaire were used for data collection. Descriptive results indicated that organizational performance was at a relatively high level, and health communication was also evaluated at a desirable level. Based on the Kolmogorov-Smirnov test, the distribution of the main variables was normal, and the necessary assumptions for conducting regression analysis were met. Correlational findings showed a positive and significant relationship between organizational performance and all subscales of health communication, with the highest correlation observed between organizational performance and total health communication. The results of multiple regression also indicated that health communication positively and significantly predicts organizational performance, and approximately one-quarter of the variance in organizational performance is explained by health communication. These results emphasize the importance of enhancing health communication skills in improving the organizational performance of clinic employees and can serve as a guide for educational and managerial planning in the healthcare system.

**Keywords:** Health communication, organizational performance, verbal and non-verbal skills, conscious initiation, unconditional acceptance of the client

## Introduction

In the contemporary landscape of service-oriented sectors, the conceptualization and measurement of organizational performance have evolved significantly, moving beyond mere financial metrics to encompass a holistic view of human capital, structural efficiency, and interpersonal dynamics. To understand the multifaceted nature of organizational performance, researchers frequently examine highly interactive service environments, such as the hospitality industry, which shares fundamental similarities with the healthcare sector regarding client interaction and service delivery. For instance, recent analyses highlight the detrimental effects of organizational


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inertia on employee innovative behavior, demonstrating that a rigid organizational structure inherently stifles the adaptive capabilities required to sustain high organizational performance (1). Furthermore, how employees perceive their organization's structure directly influences critical operational outcomes, including organizational commitment, job satisfaction, and perceived overall performance (2). In such human-centric industries, the effective management of personnel—specifically mitigating employee turnover—is inextricably linked to the preservation of institutional knowledge and the optimization of organizational performance (3). The parallels between these service sectors and healthcare are profound; both require high levels of responsiveness, empathy, and coordinated teamwork to achieve superior organizational outcomes.

Applying these broader organizational principles to the healthcare sector reveals a complex ecosystem where clinical efficacy and operational efficiency must coexist. In healthcare organizations, evaluating performance requires specialized indicators that align with higher-level policy documents and national health strategies to ensure comprehensive care delivery (4). Financial viability remains a cornerstone of this performance, as evidenced by dynamic panel analyses demonstrating the critical relationship between capital efficiency—such as the weighted average cost of capital and return on assets—and the sustained operational success of healthcare infrastructures (5). However, financial and structural mechanisms are heavily moderated by internal cultural factors. The implementation of robust risk management and internal control systems only translates to optimal performance when supported by a congruent organizational culture (6). Similarly, within hospital settings, leadership paradigms, particularly servant leadership, play a pivotal role in shaping an organizational culture that directly enhances employee performance and, by extension, the quality of patient care (7).

To fully comprehend the depth of organizational culture and its impact on performance, it is highly instructive to draw upon the extensive theoretical frameworks established in the field of educational administration. Schools, much like medical clinics, operate as profound cultural arenas characterized by deeply ingrained symbols, rituals, and symbolic activities that dictate the roles and behaviors of their members (8). The conceptualization of these institutions as distinct cultural ecosystems provides a crucial lens for understanding how shared values and norms influence structural operations and overall institutional effectiveness (9). Seminal research has long established that a cohesive and positive organizational culture is a primary determinant of an institution's effectiveness and its capacity for sustained improvement (10). Furthermore, understanding the pathology of an organization's culture based on competitive values frameworks allows administrators to identify systemic dysfunctions that hinder performance, whether in a school district or a regional health clinic (11). The typology and shaping fields of these organizational cultures are not static; they are dynamically influenced by internal policies, external environmental pressures, and the localized interactions of staff members (12).

The continuous shaping and assessment of this culture require active, intentional leadership. Leaders act as the primary forces for systemic change, driving the institutional mindset toward innovation, accountability, and collective efficacy (13). Cultivating a new, adaptive organizational culture necessitates a deliberate departure from entrenched, obsolete practices—a process that requires specific diagnostic tools to accurately assess the existing cultural climate and implement targeted improvement strategies (14). Fieldbooks and practical guides developed for shaping institutional culture emphasize that transforming a workplace involves aligning daily operational behaviors with the core mission and values of the organization (15). When leaders successfully shape this new culture, they create an environment where collaboration and continuous learning become the norm (16). Even within highly specialized academic and research cultures, such as those governing technology transfer in prominent

universities, the intrinsic pursuit of knowledge and institutional values heavily dictate how effectively the organization translates its intellectual capital into practical, high-performing outcomes (17). Crucially, a multidimensional, supportive organizational culture directly fosters adolescent empathy and prosocial behavior in educational settings; similarly, in healthcare settings, a supportive clinic culture fosters the empathy and prosocial behaviors required by medical staff to deliver patient-centered care (18).

Building upon these foundational concepts of organizational culture and institutional environments, the specific discipline of health promotion emerges as a vital bridge connecting organizational policies to individual well-being. The development of health-promoting environments, whether in schools or clinics, requires exploring systemic strengths, addressing operational challenges, and implementing strategic improvement initiatives guided by expert consensus (19). A fundamental prerequisite for the success of these initiatives is the baseline health literacy of the individuals operating within the system. For instance, evaluating the health literacy of professionals, such as teachers or clinic administrators, provides insight into their capacity to process, understand, and effectively communicate vital health information to their respective constituents (20). This continuous transfer of information forms the bedrock of an organization's internal and external communicative competence.

At the micro-level of healthcare delivery, these cultural and systemic factors converge in the practice of health communication. Health communication encompasses a broad array of concepts, behavioral theories, and practical implications that are indispensable to the functioning of the modern health system (21). It is not merely the exchange of clinical data; rather, it represents the operationalization of the clinic's organizational culture. The human factor is undeniably the most critical element in healthcare, where effective teamwork and seamless communication are absolute prerequisites for mitigating errors and providing safe, high-quality care (22). When healthcare providers purposefully enhance their communication strategies—coordinating both internally with colleagues and externally with patients—they significantly improve overall patient safety metrics and operational efficiency (23). Furthermore, the pathways linking clinician-patient communication to actual health outcomes are well-documented; communication functions as a therapeutic tool that heals through building trust, establishing mutual understanding, and fostering unconditional acceptance between the provider and the client (24).

Despite the extensive literature affirming the critical importance of communication in clinical outcomes, there remains a significant gap in understanding how specific, granular dimensions of health communication directly predict broader organizational performance from an administrative and operational standpoint. Health communication is a multidimensional construct that includes the conscious initiation of interactions, mastery of verbal and non-verbal skills, meticulous external and internal coordination, profound respect for the client, and an attitude of unconditional acceptance. While previous studies have extensively researched these communication variables in the context of patient satisfaction and medical adherence, their aggregate impact on the institutional performance of the healthcare facility itself requires rigorous quantitative investigation. In modern healthcare ecosystems, private and public clinics operate under varying structural, financial, and cultural pressures. Public clinics often grapple with high patient volumes and bureaucratic constraints, whereas private clinics frequently emphasize service differentiation and client retention in a competitive market. Regardless of these structural differences, the fundamental premise remains that a clinic's workforce relies heavily on interpersonal communication to navigate daily challenges, execute complex medical directives, and maintain a cohesive organizational culture.

If educational and corporate service industries rely on structural alignment, cultural cohesion, and clear communication to drive performance, it logically follows that the mastery of health communication dimensions by clinic employees should serve as a powerful predictor of organizational success in healthcare settings. When medical staff and clinic employees exhibit high levels of verbal and non-verbal communication skills, and when their interactions are characterized by respect and conscious initiation, the resulting organizational climate is likely to be highly efficient, collaborative, and responsive. Such an environment not only minimizes systemic errors and employee turnover but also maximizes resource utilization and overall operational efficacy. Therefore, empirical evaluation is necessary to quantify the exact correlational and predictive relationships between these specific subscales of health communication and the standardized metrics of organizational performance. By doing so, healthcare administrators can move beyond generic cultural assessments and implement targeted, evidence-based communication training programs designed not only to improve patient health outcomes but to systematically elevate the functional performance of the medical institution itself. Based on the theoretical frameworks and identified empirical gaps outlined above, the present study aimed to investigate the relationship between health communication (and its various subscales) and organizational performance among employees of private and public clinics.

## Methods and Materials

The present study is applied in terms of purpose, and descriptive-correlational in terms of nature and implementation method. In this study, the researcher sought to explain the relationship between health communication and organizational performance among employees of public and private clinics, and measured the current situation without any manipulation of the variables. For this purpose, the conceptual model of the research was first developed by reviewing the theoretical literature and the background of domestic and foreign studies related to health communication and organizational performance. Then, based on this model, the measurement tools for health communication and organizational performance were selected or developed, and data were collected through standard self-report questionnaires. Considering that the main objective was to investigate the “relationship” and “predictive power” of health communication in explaining organizational performance, after data preparation, descriptive statistics were used to describe the sample characteristics, and inferential statistics, including the Pearson correlation coefficient and multiple linear regression, were used to test the hypotheses.

The statistical population of this research consisted of all employees working in public and private clinics (physicians, nurses, administrative and reception staff) in a specific city/province during the year of the research implementation. Due to time and accessibility constraints, the research sample was selected from among eligible employees (having at least one year of work experience in the respective clinic and a willingness to participate in the research). The sampling method in this research was convenience sampling; in this manner, after obtaining the necessary permissions from the clinic management, the questionnaires were provided to the employees, and those who declared their informed consent to participate in the study were included in the sample. The sample size was determined based on the research objectives and citing methodological recommendations for correlation and regression analysis (at least 10to 15subjects per predictor variable), as well as considering the potential dropout of respondents. Finally, after the refinement and removal of incomplete questionnaires, the collected data were entered into appropriate statistical software and analyzed to investigate and compare the relationship between health communication and the organizational performance of employees in public and private clinics.

## Findings and Results

Table 1 presents the frequency and percentage distribution of the employees' demographic variables. Based on the provided data, 57%of the employees are male and 43%are female. In terms of age groups, the highest percentage of employees is in the 35-45 years age range with 39.7%, while the lowest percentage belongs to the over 55years age group with 19.3%. Regarding work experience, the highest percentage of employees, at 31.7%, is in the 5to 10years of work experience group, whereas the group with less than 5years of work experience accounts for the lowest percentage at 10%.

**Table 1: Frequency and percentage distribution of employees' demographic variables**

| Variables | | Count | Percentage |
|---|---|---|---|
| Gender | Male | 171 | 57 |
| | Female | 129 | 43 |
| | Total | 300 | 100 |
| Age Groups | 25-35 | 60 | 20 |
| | 35-45 | 119 | 39.7 |
| | 45-55 | 63 | 21 |
| | Over 55years | 58 | 19.3 |
| | Total | 300 | 100 |
| Work Experience | Less than 5years | 30 | 10 |
| | 5-10 | 95 | 31.7 |
| | 10-15 | 87 | 29 |
| | 15-20 | 53 | 17.7 |
| | Over 20years | 35 | 11.7 |
| | Total | 300 | 100 |

The interpretation of the total scores of the variables indicates the overall status of organizational performance and health communication. For the organizational performance variable, a total score of 130.16with a standard deviation of 22.70means that the mean of organizational performance scores is at a high level, but a large variation is also observed among individuals' scores. This indicates significant differences in the various evaluations of employees regarding organizational performance. For the health communication variable, a total score of 87.27with a standard deviation of 15.58means that the mean score for this variable is also at a desirable level, but it has less variation compared to organizational performance. This difference in standard deviation shows that individuals have reached slightly more consensus in their evaluation of health communication.

**Table 2: Description and examination of the main research variables**

| Variable | Subscale | Minimum | Maximum | Mean | Standard Deviation |
|---|---|---|---|---|---|
| Organizational Performance | Ability | 4 | 20 | 12.85 | 2.75 |
| | Clarity | 7 | 35 | 21.55 | 4.78 |
| | Help | 5 | 25 | 15.30 | 3.44 |
| | Incentive | 6 | 30 | 18.94 | 4.11 |
| | Evaluation | 9 | 45 | 27.68 | 6.17 |
| | Validity | 6 | 30 | 18.16 | 4.13 |
| | Environment | 5 | 25 | 15.68 | 3.43 |
| | Total Organizational Performance | 56 | 201 | 130.16 | 22.70 |
| Health Communication | Conscious Initiation | 5 | 25 | 15.93 | 3.44 |
| | Verbal and Non-verbal Communication Skills | 6 | 30 | 18.33 | 4.10 |
| | External and Internal Coordination | 4 | 20 | 12.62 | 2.75 |
| | Respect for the Client | 5 | 25 | 15.70 | 3.39 |
| | Unconditional Acceptance of the Client | 8 | 40 | 24.68 | 5.51 |
| | Total Health Communication | 40 | 128 | 87.27 | 15.58 |

Before examining and analyzing each of the main and secondary research hypotheses using the multiple linear regression method, the assumptions of this statistical analysis—which include checking the normality of the research variables, the correlation between criterion and predictor variables, and the absence of multicollinearity among predictor variables—must first be analyzed. If these assumptions are confirmed, linear regression can be used to investigate the research hypotheses.

One of the most important assumptions for conducting linear regression is checking the normality of the research variables, which is performed using the Kolmogorov-Smirnov test, and its results are as follows:

**Table 3: Kolmogorov-Smirnov test for examining the normal distribution of research data**

| Variables | K-S Statistic | Significance |
|---|---|---|
| Organizational Performance | 0.034 | 0.200 |
| Health Communication | 0.037 | 0.200 |

Table 3 shows that the calculated significance level for all main research variables is higher than the 0.05error level; therefore, it can be stated that the variables have a normal and standard distribution in terms of inferential statistics.

**Table 4: Examining the correlation among research variables using the Pearson correlation coefficient test**

| Variables | Total Organizational Performance | Conscious Initiation | Verbal and Non-verbal Communication Skills | External and Internal Coordination | Respect for the Client | Unconditional Acceptance of the Client | Total Health Communication |
|---|---|---|---|---|---|---|---|
| Total Organizational Performance | 1 | | | | | | |
| Conscious Initiation | 0.401** | 1 | | | | | |
| Verbal and Non-verbal Communication Skills | 0.432** | 0.569** | 1 | | | | |
| External and Internal Coordination | 0.374** | 0.599** | 0.565** | 1 | | | |
| Respect for the Client | 0.380** | 0.565** | 0.523** | 0.540** | 1 | | |
| Unconditional Acceptance of the Client | 0.426** | 0.579** | 0.587** | 0.592** | 0.529** | 1 | |
| Total Health Communication | 0.502** | 0.805** | 0.811** | 0.785** | 0.763** | 0.857** | 1 |

**Significant at the 0.01error level.

Examining the correlation among the variables shows that organizational performance has a positive and significant correlation with all health communication subscales. The highest correlation is observed between organizational performance and total health communication with a correlation coefficient of 0.502. Also, there are significant correlations between organizational performance and other subscales such as conscious initiation (0.401), verbal and non-verbal communication skills (0.432), and unconditional acceptance of the client (0.426). These results indicate that improving organizational performance is associated with enhancing quality in health communication.

Another important assumption in conducting linear regression is checking for the absence of multicollinearity or strong correlation between predictor variables in the model, which is performed by two statistics: Tolerance and Variance Inflation Factor (VIF) in the regression model, and the results are as follows:

**Table 5: Examining the absence of multicollinearity among predictor variables**

| Predictor Variables | Tolerance | Variance Inflation Factor |
|---|---|---|
| Conscious Initiation | 0.498 | 2.007 |
| Verbal and Non-verbal Communication Skills | 0.531 | 1.883 |
| External and Internal Coordination | 0.505 | 1.980 |
| Respect for the Client | 0.574 | 1.741 |
| Unconditional Acceptance of the Client | 0.508 | 1.967 |

Table 5 shows that the value of the Tolerance statistic for the predictor variables is higher than 0.1; additionally, the value of the Variance Inflation Factor statistic is less than 10. Consequently, it can be stated that the absence of multicollinearity among the predictor variables in the model is confirmed.

**Table 6: Investigating the relationship between health communication (and its subscales) and organizational performance among employees of private and public clinics**

| Predictor Variable | Unstandardized Coefficient ($B$) | Standardized Coefficient ($\beta$) | $t$ | Significance ($p$) | Correlation ($r$) | Coefficient of Determination ($R^2$) |
|---|---|---|---|---|---|---|
| Total Health Communication | 0.732 | 0.502 | 10.021 | 0.001 | 0.502 | 0.252 |
| Conscious Initiation of Communication | 2.642 | 0.401 | 7.556 | 0.001 | 0.401 | 0.161 |
| Verbal and Non-verbal Communication Skills | 2.393 | 0.432 | 8.272 | 0.001 | 0.432 | 0.187 |
| External and Internal Coordination of Communication | 3.079 | 0.374 | 6.954 | 0.001 | 0.374 | 0.140 |
| Respect for the Client | 2.541 | 0.380 | 7.098 | 0.001 | 0.380 | 0.145 |
| Unconditional Acceptance | 1.753 | 0.426 | 8.121 | 0.001 | 0.426 | 0.181 |

Table 6 illustrates the results of regression analyses investigating the relationship between health communication, including its various subscales, and organizational performance among employees of private and public clinics. The findings demonstrate a positive and significant relationship between total health communication and organizational performance ($B = 0.732$, $\beta = 0.502$, $t = 10.021$, $p = 0.001$), confirming the main hypothesis and indicating that 25.2%of the variance in organizational performance is explained by health communication ($R^2 = 0.252$). Similarly, all secondary hypotheses were confirmed, revealing that organizational performance is positively and significantly predicted by conscious initiation of communication ($B = 2.642$, $\beta = 0.401$, $t = 7.556$, $p = 0.001$, $R^2 = 0.161$), verbal and non-verbal communication skills ($B = 2.393$, $\beta = 0.432$, $t = 8.272$, $p = 0.001$, $R^2 = 0.187$), external and internal coordination of communication ($B = 3.079$, $\beta = 0.374$, $t = 6.954$, $p = 0.001$, $R^2 = 0.140$), respect for the client ($B = 2.541$, $\beta = 0.380$, $t = 7.098$, $p = 0.001$, $R^2 = 0.145$), and unconditional acceptance ($B = 1.753$, $\beta = 0.426$, $t = 8.121$, $p = 0.001$, $R^2 = 0.181$). Overall, these results indicate that an increase in total health communication and its dimensions leads to a significant improvement in the organizational performance of clinic employees.

## Discussion and Conclusion

The primary objective of the current study was to investigate the relationship between health communication, including its various subscales, and organizational performance among employees of private and public clinics. The empirical results yielded a robust confirmation of both the main hypothesis and all secondary hypotheses. Specifically, the findings demonstrated a positive and highly significant relationship between total health communication and organizational performance ($p = 0.001$). The regression analysis revealed that total health communication explains a substantial portion of the variance in organizational performance ($R^2 = 0.252$). Furthermore, the subscales of health communication—namely, conscious initiation of communication ($R^2 = 0.161$), verbal and non-verbal communication skills ($R^2 = 0.187$), external and internal coordination of communication ($R^2 = 0.140$), respect for the client ($R^2 = 0.145$), and unconditional acceptance ($R^2 = 0.181$)—all emerged as significant, positive predictors of organizational performance. These results unequivocally indicate that as the quality and frequency of health communication dimensions increase among clinic employees, there is a commensurate and significant improvement in the overall operational and organizational performance of the healthcare facility.

The significant predictive power of total health communication on organizational performance aligns seamlessly with recent evaluations of health systems. Performance evaluation indicators in healthcare are deeply tied to the human elements of service delivery, as foundational health documents increasingly emphasize the quality of interpersonal interactions (4). The conceptualization of health communication extends far beyond simple information transfer; it is deeply embedded in the theories and implications of how a health system fundamentally operates (21). When a healthcare organization fosters an environment where communication flows effectively, it mitigates the risks associated with poor internal controls and enhances overall institutional performance (6). This is supported by findings indicating that servant leadership and a positive organizational culture, which rely heavily on open communication, are critical for maximizing employee performance in hospital settings (7).

Examining the specific subscales, the conscious initiation of communication and the mastery of verbal and non-verbal communication skills were found to significantly predict performance. This can be explained by the fact that proactive communication breaks down organizational inertia. When employees actively initiate communication and utilize strong verbal and non-verbal skills, they foster innovative behaviors and overcome rigid organizational structures, leading to enhanced performance (1). In the high-stakes environment of healthcare, the human factor is paramount; effective teamwork and precise verbal and non-verbal communication are absolutely critical for providing safe care and preventing systemic failures (22). By purposefully enhancing these communication strategies, healthcare providers directly improve patient safety and operational efficiency (23). The ability to communicate clearly and initiate necessary clinical dialogues ensures that potential errors are caught early, thereby boosting the clinic's overall performance metrics.

Furthermore, the results indicating that external and internal coordination of communication significantly influences organizational performance are strongly supported by broader organizational research. The perception of how an organization is structured, and how effectively different departments coordinate, directly impacts employee commitment, job satisfaction, and perceived performance (2). In institutions like schools and clinics, which serve as complex cultural arenas, symbols and symbolic activities of coordination are vital for structural integrity (8). Effective coordination weaves the fabric of the organization's culture, dictating how roles are executed (9). When

internal coordination is high, the institution operates cohesively, which is a primary determinant of overall effectiveness and the capacity for continuous improvement (10).

The dimensions of respect for the client and unconditional acceptance also proved to be significant predictors of organizational performance. These findings are deeply rooted in the therapeutic nature of clinical interactions. Clinician-patient communication pathways that are built on respect and unconditional acceptance are known to facilitate healing and directly improve health outcomes (24). In organizational settings, fostering empathy and prosocial behaviors—which are analogous to respect and acceptance in a clinical setting—creates a supportive multidimensional culture that elevates the entire institution (18). Leaders who utilize specific tools to assess and improve these cultural aspects ensure that respect becomes a foundational pillar of the organization's daily operations (14).

The synthesis of these findings highlights the profound parallel between healthcare facilities and other highly structured cultural environments, such as educational institutions. Identifying the pathology of an organization's culture based on competitive values is essential for removing barriers to performance (11). The typology and shaping fields of organizational culture dictate how employees interact with one another and with their clients (12). Shaping this culture requires deliberate action, utilizing fieldbooks and strategic frameworks to align daily behaviors with institutional goals (15). When leaders act as forces for change, they can cultivate a new, highly effective culture centered on communication (13). This new school of thought within the organization prioritizes continuous learning and mutual respect (16). Even in highly specialized academic and technological transfer environments, the underlying academic culture dictates the ultimate success of the institution (17).

Ultimately, maintaining a high-performing organization requires managing employee turnover, as retaining skilled staff preserves institutional knowledge and communication competencies (3). Furthermore, while financial metrics like capital efficiency are critical for organizational viability, they must be supported by the human elements of communication to achieve sustainable performance (5). Building health-promoting environments requires exploring structural strengths and implementing strategies that rely on the health literacy and communicative abilities of the staff (19). Ensuring that employees have the foundational health literacy to engage in effective health communication is therefore a necessary precursor to achieving high organizational performance (20). By confirming the strong predictive relationship between all dimensions of health communication and organizational performance, this study provides empirical validation that communication is not merely a soft skill, but a core driver of institutional success.

Despite the robust findings presented in this study, several limitations must be acknowledged. First, the research relied heavily on self-report questionnaires to measure both health communication and organizational performance. Self-report measures are inherently susceptible to social desirability bias, where respondents may overestimate their communication skills or the performance of their clinic to present themselves or their organization in a more favorable light. Second, the cross-sectional design of the study restricts the ability to draw definitive causal inferences. While the regression models indicate that health communication predicts organizational performance, it is also plausible that high-performing organizations naturally foster better communication environments, suggesting a bidirectional relationship that cannot be fully captured at a single point in time. Additionally, the sample was drawn through convenience sampling from specific private and public clinics, which may limit the generalizability of the findings to broader healthcare systems, rural clinics, or massive hospital conglomerates with vastly different organizational hierarchies and resources. Finally, the study did not control for extraneous variables

such as the specific medical specialties of the clinics, the baseline financial health of the organizations, or the individual psychological well-being of the employees, all of which could independently influence organizational performance.

To build upon the findings of this study and address its limitations, future research should employ longitudinal designs to establish a clearer causal trajectory between the development of health communication skills and subsequent changes in organizational performance over time. Researchers are encouraged to utilize mixed-methods approaches that combine quantitative survey data with qualitative observations, patient feedback, and objective administrative metrics (such as patient wait times, error rates, and employee retention figures) to provide a more comprehensive and objective evaluation of organizational performance. Furthermore, future studies should aim for stratified random sampling across a wider geographic and structural array of healthcare facilities to enhance external validity. Investigating the potential moderating or mediating variables in this relationship would also be highly beneficial. For example, exploring how leadership styles, emotional intelligence, or specific technological communication platforms (such as electronic health record messaging systems) mediate the impact of interpersonal health communication on institutional performance could yield deeper insights into the mechanisms driving organizational success.

Based on the empirical evidence demonstrating that health communication heavily dictates organizational performance, healthcare administrators and clinic managers should prioritize the implementation of structured, mandatory communication training programs for all staff members. These programs should not be limited to clinical personnel but must include administrative and support staff, focusing specifically on conscious initiation of interactions, active listening, and non-verbal awareness. To improve external and internal coordination, clinics should establish standardized communication protocols and regular interdepartmental briefings to ensure that information flows seamlessly across the organization, thereby reducing operational bottlenecks and systemic errors. Furthermore, management should actively cultivate an organizational culture that rewards empathy, unconditional acceptance, and respect for the client. This can be achieved through regular performance evaluations that specifically weigh interpersonal communication competencies alongside technical skills. By integrating these communication-focused strategies into daily operational policies, clinics can effectively reduce staff turnover, enhance patient satisfaction, and significantly elevate their overall organizational performance.

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## Authors' Contributions

All authors equally contributed to this study.

## Declaration of Interest

The authors of this article declared no conflict of interest.

## Ethical Considerations

All ethical principles were adheried in conducting and writing this article.

## Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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