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From Anxiety to Trust: A Transcendental Phenomenology of Dyadic Doctor–Patient Communication in Medical Decision–Making at an Indonesian Hospital

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Abstract: Effective doctor–patient communication remains a global problem: surveys across ten countries reveal wide perception gaps between doctors and patients, and in Indonesia 35% of patients report dissatisfaction with consultation communication, while prior research remains predominantly quantitative and overlooks the lived experience that constitutes the dyadic relationship. This study aims to explore the development of the doctor–patient communication relationship through the patient's active involvement, the communication experiences of both parties, and the transcendental meaning of their dyadic relationship for patient centered care and the biopsychosocial model. Using an interpretive paradigm and a descriptive qualitative approach, Edmund Husserl's transcendental phenomenology was applied through epoché, phenomenological reduction, imaginative variation, and synthesis of meaning to three purposively selected doctor–patient dyads—an internist, a pediatrician, and an obstetrician–gynecologist with their respective patients—at Hospital 123, Indonesia; data were collected through participant observation and in-depth semi-structured and unstructured interviews, and validated through triangulation of techniques, sources, and time. The results show that the relationship develops in stages, from digital pre-consultation information seeking through the orientation, affective exploration, affective, and stable levels, culminating in shared decision-making; the lived experience transforms patient anxiety into trust through the doctor's empathic presence; and self-disclosure expands to include prayer, empathy, and respect, yielding a biopsychosocial–spiritual–cultural perspective. The study concludes that clinical communication is a humanizing encounter in which professional competence and empathy together restore the patient's dignity, and it offers a four-level dyadic communication model for evaluating patient-centeredness in hospitals.

Keywords: Dyadic Communication, Doctor–Patient Relationship, Social Penetration, Transcendental Phenomenology, Patient Centered Care.

INTRODUCTION

Communication is a key element of every human interaction, and its role is particularly critical in healthcare services. Doctor–patient communication is a form of dyadic communication, an interpersonal exchange involving two individuals, in which the doctor acts not only as a provider of medical information but also as a listener who understands the patient's emotional and psychological needs. Effective dyadic communication builds trust and openness, reduces the anxiety and uncertainty patients often feel during consultations, and enables both parties to determine treatment plans collaboratively; patients who feel heard are more willing to disclose important information, which in turn supports accurate diagnoses and shared decision-making (Epstein & Street, 2007). Conversely, poor communication leads to misunderstanding, misdiagnosis, and declining patient satisfaction. Empirically, this ideal is difficult to achieve: doctors face heavy workloads and limited consultation time that make interactions feel rushed, while patients experience anxiety and difficulty articulating their complaints. In Asian countries, including Indonesia, social hierarchy further shapes the interaction, as patients tend to follow the doctor's direction without openly expressing their concerns (Roter & Hall, 2006). These dynamics make the dyadic communication between doctors and patients at Hospital 123 a compelling phenomenon to examine.

Survey data from various countries confirm that this communication problem is a global empirical fact. In the United States, 75% of orthopedic surgeons believed they communicated well, yet only 21% of their patients agreed, revealing a wide perception gap (Tongue, Epps, & Forese, 2005). In the United Kingdom, 54% of patients felt their doctors did not provide sufficient information about their condition (Coulter, 2006); in Canada, 40% reported that their doctors did not listen attentively (Canadian Medical Association, 2007); in Australia, 32% felt excluded from medical decisions affecting them (Australian Commission on Safety and Quality in Health Care, 2010); and in Germany, 58% wanted more information about treatment options (IQWiG, 2011). Similar patterns appear in Japan, where 45% of patients complained that side effects were insufficiently explained (Ishikawa, Hashimoto, & Kiuchi, 2013), in Brazil, where 37% struggled to understand medical terminology (Mendes et al., 2016), in India, where 41% were given no opportunity to ask questions (Rao & Rao, 2017), and in Nigeria, where 50% perceived a lack of empathy from their doctors (Ogundele & Ojo, 2018). In Indonesia, 35% of patients were dissatisfied with the communication they received during consultations (Setiawan, 2019), a condition that indicates a gap in the implementation of Article 6 of the Indonesian Medical Code of Ethics, which obliges doctors to provide clear, complete, and truthful information and to respect patient autonomy (KODEKI, 2012).

Previous research has consistently linked the quality of the doctor–patient relationship to clinical outcomes and patient satisfaction. Epstein and Street (2011) found that patient-centered communication allows doctors to understand patients' concerns comprehensively—physically, emotionally, and socially—and increases adherence to treatment. Studies using the Roter Interaction Analysis System show that patient satisfaction is positively influenced by doctors who actively explore psychosocial topics and negatively influenced by dominant communication styles (Bertakis, Roter, & Putnam, 1991; Roter et al., 1997, in Harrington, 2015), and that communication is shaped by patient and provider characteristics such as information preferences, gender, and demographic concordance (Chewning et al., 2012; Roter, Hall, & Aoki, 2002, in Harrington, 2015). Phenomenological studies report that patients feel more heard and empowered when doctors show genuine empathy and involve them in treatment discussions (Laine & Davidoff, 1996; Larsson et al., 2011; Rise et al., 2013). At the same time, this body of research reveals persistent shortcomings: the implementation of *patient centered care* remains inconsistent (Elwyn, Edwards, & Kinnersley, 1999), and many doctors still focus on biomedical aspects while neglecting the social and emotional factors emphasized by the biopsychosocial model (Borrell-Carrió et al., 2004; Fortes et al., 2008). These findings

reflect the broader paradigm shift in medicine from a paternalistic, biomedical model toward *patient centered care* grounded in a holistic biopsychosocial view of the patient (Stewart et al., 2014; Bolton & Gillett, 2019).

From these descriptions, a research gap emerges between expectation and reality—between *das sollen*, the ideal of open, trusting, and empathetic communication, and *das sein*, the reality of rigid, hierarchical interactions in which patients remain passive and withhold information that affects the quality of diagnosis and care (Stewart, 2001; Roter & Hall, 2006). Theoretically, this problem can be explained by Social Penetration Theory, which holds that interpersonal relationships develop through gradual self-disclosure from the superficial orientation stage to a stable stage of full openness and trust, a progression often obstructed by time constraints and sociocultural differences (Altman & Taylor, 1973), and by Relational Dialectics Theory, which highlights the tension between the patient's need for protection and the demand for openness, as well as the doctor's dilemma between informing fully and maintaining authority and efficiency (Baxter & Montgomery, 1998). However, most previous studies have been quantitative and outcome-oriented, so the subjective lived experience that constitutes the dyadic relationship remains underexplored. This study addresses that gap through Edmund Husserl's transcendental phenomenology, employing *epoché*—the suspension of assumptions and prejudices—to grasp how doctors and patients genuinely make meaning of their interactions, including the verbal, nonverbal, and emotional dimensions that quantitative approaches often miss (Husserl, 1970; Moustakas, 1994).

Based on this background, the objective of this research is to explore and deeply understand the process of developing the communication relationship between doctors and patients in health consultations at Hospital 123. Specifically, this study aims to: (1) analyze the process of developing the doctor–patient communication relationship through the patient's active involvement during medical consultations; (2) explore the communication experiences of doctors and patients in the consultation process to understand how those experiences shape the development of their interpersonal relationship; and (3) analyze the transcendental meaning of the doctor–patient dyadic relationship and its contribution to the development of *patient centered care* and the biopsychosocial approach, by revealing the factors that influence effective and empathetic communication. This study assumes that effective communication is a vital component affecting not only diagnosis and treatment but also the overall quality of the patient's healthcare experience, so that by examining the barriers to communication—such as anxiety and lack of openness—it can offer new insights for creating a more empathetic and supportive communication environment and contribute, theoretically and practically, to improving the quality of health services in Indonesia and beyond.

METHOD

This study uses an interpretive paradigm, which views social reality as something constructed through the interaction of individuals and focuses on uncovering the subjective meanings underlying human behavior rather than measuring, generalizing, or predicting it (Creswell & Creswell, 2018; Harrington, 2015). Consistent with this paradigm, the research adopts a descriptive qualitative approach, which is appropriate because the object of study—the development of the doctor–patient communication relationship—is a process to be understood holistically through words and language in natural settings rather than quantified (Creswell, 2007; Sugiyono, 2020). The specific method employed is Edmund Husserl's transcendental phenomenology, which studies the structure of conscious experience from the first-person perspective and seeks the meaning and essence of lived experience within the *Lebenswelt* (life-world) (Kuswarno, 2009; Moustakas, 1994). Following this tradition, the researcher suspended all preconceptions, theories, and assumptions through *epoché* or *bracketing* so that the phenomenon could be grasped as it is directly experienced by the

participants, making the research inductive: it departs from field data, constructs meaning, and only then relates the findings to theory—particularly the stages of Social Penetration (orientation, exploratory affective, affective, stable, and depenetration)—to capture the authentic essence of doctor–patient communication experiences (Giorgi, 2006).

The research subjects were determined purposively (Sugiyono, 2020) through the official procedures of Hospital 123 in South Tangerang, Banten, and consist of two groups in three dyadic pairs: three specialist doctors practicing permanently at the hospital—an internist, a pediatrician, and an obstetrician–gynecologist—as resource persons, and one patient of each doctor as informants, namely an adult patient, the parent of a pediatric patient as the medical decision-maker, and a pregnant woman whose decisions also involve her husband. Doctors were proposed by the researcher and approved by the hospital, while patients were appointed by the hospital with the doctor's consent to protect patients' health conditions and medical confidentiality, ensuring an ethical and transparent selection process. Data were collected by positioning the researcher as a participant observer who directly witnessed consultation interactions while recording conversations, body language, facial expressions, and emotional atmosphere, and through semi-structured and unstructured in-depth interviews that allowed problems to be revealed openly (Creswell & Creswell, 2018; Groenewald, 2004). Interview results were transcribed to capture not only what was said but also how it was said, including intonation, emphasis, pauses, and laughter (Hepburn & Bolden, 2012, in Harrington, 2015), and were complemented, where consent was granted, by relevant medical documents.

Data validity was established through triangulation (Creswell & Creswell, 2018; Sarantakos, 2013) in three forms: triangulation of techniques, combining non-participant observation of consultations, in-depth interviews, and document review; triangulation of sources, comparing the perspectives of doctors, patients, and, where relevant, family members; and triangulation of time, interviewing patients both before consultations, about their expectations and worries, and afterwards, about their understanding and feelings once decisions were made. Data were then analyzed through the phenomenological stages of *bracketing*, setting aside the researcher's prior beliefs about the phenomenon; *intuiting*, remaining open to the meanings expressed by those who experienced it; *analyzing*; and *describing* (Amal, 2019; Sarantakos, 2013), following Husserl's phenomenological reduction: capturing the whole story of the experience as expressed, analyzing the description into parts to grasp their meanings, formulating the theoretical meaning of the participants' lived experience, and making a constructive imaginative leap to the essential truth of that experience as a human experience (Giorgi, 2006). The analysis explores both the textural dimension (what was experienced) and the structural dimension (how the experience was formed) to reveal the essence of doctor–patient communication in medical consultations.

RESULTS AND DISCUSSION

The results are presented following the methodological stages of transcendental phenomenology—*epoché*, phenomenological reduction, imaginative variation, and synthesis of meaning—to uncover the essence of doctor–patient communication experiences through their textural (what was experienced) and structural (how the experience was formed) dimensions. The study took place at Hospital 123, a referral hospital whose service policy is explicitly based on *patient centered care*, so the dyadic dynamics observed represent realistic, non-experimental medical practice. Every consultation observed followed a consistent communicative skeleton: after informed consent, the encounter moved from opening conversation, information gathering, delivery of diagnosis, joint determination of follow-up actions (medical procedures or prescriptions), to closing and scheduled control—a continuous cycle documented through the SOAP framework (Subjective, Objective, Assessment, Plan), a structured, analysis-oriented medical recording method that simultaneously functions as a map

of the communication stages in each session (Jaroudi & Payne, 2019). Two contextual settings colored these encounters: in the hospital, communication tended to be formal and structured because doctors were bound by service systems, time limits, and institutional professionalism, while in private practice communication was warmer and more personal, confirming that atmosphere and interpersonal context are integral to the quality of dyadic communication.

Addressing the first objective, the findings show that self-disclosure between doctor and patient develops gradually through the patient's active involvement, and that the process begins even before the first face-to-face encounter. All three patient informants started with a pre-consultation search for doctor information via digital platforms—hospital websites, Google reviews, social media accounts, and recommendations from relatives or community—which formed initial impressions and baseline trust. Mrs. S, after moving cities, chose dr. X (pediatrician) based on digital traces and was strengthened by a first meeting with a friendly, fashionable, patient young doctor who welcomed questions, shared complete medical information, and remained reachable through WhatsApp in emergencies; over years of routine visits for her child A's asthma, the relationship grew from formal caution into a family-like bond. Mrs. B came to dr. Y (internist) carrying anxiety and a deep fear of needles before a knee-injection procedure; the doctor's calm smile, gentle speech, attentive gaze, and non-judgmental manner became, in her words, a bridge between fear and the courage to open up, so that across two sessions she began sharing personal stories about past treatments. Mrs. C experienced the most intense trajectory with dr. Z (obstetrician–gynecologist): across six consultations in early 2025, from initial uncertainty, through pathology results indicating cancer cells, to the major decision of hysterectomy taken after family deliberation, and finally a post-operative control marked by relief and gratitude. In all three dyads, disclosure was not limited to the exchange of personal information; it included prayer, expressions of empathy, and respect—an Indonesian cultural-spiritual enrichment of the *self-disclosure* stage in Social Penetration Theory (Altman & Taylor, 1973). Table 1 synthesizes the cross-case phenomenological analysis of the three dyads according to the four penetration stages.

Table 1. Cross-Case Synthesis of Social Penetration Stages in the Three Doctor–Patient Dyads

Stage	Doctor's Communication Behavior	Patient's Response	Essence of the Relationship
Orientation	Polite, friendly, up-to-date appearance; actively asks questions using anamnesis/SOAP; careful in diagnosing; opens room for discussion with patient/family; uses simple language.	Nervous and anxious; answers only what is asked; listens to and weighs the doctor's direction; responds with respect and openness.	Formal but warm communication; positive first impression builds basic safety and initial trust.
Affective Exploration	Patient, empathetic, and supportive; gives affirmation; builds mutual trust; explains treatment options, benefits, and risks in detail; assertive, responsive, opens up first, and remains present.	Feels comfortable, begins to open up and share deeper details and worries; assertive and responsive, though anxiety persists.	Mutual trust and emotional closeness begin to grow; self-disclosure deepens beyond surface information.
Affective	Sincere, collaborative, and democratic; provides emotional closeness and emotional support; instructive where needed for medical actions and prescriptions.	Cooperative and open; believes in recovery; follows instructions; actively listens and asks questions; anxiety decreases though a little still remains.	Shared deliberation produces decisions on medical actions and/or drug prescription.

Stable	Enthusiastic and sincere; touches hearts; bases decisions on values; explains outcomes and answers all questions; encourages the patient.	Optimistic and full of trust; actively asks questions; confident in making medical decisions together with the doctor.	Efficient, fully trusting communication; next health steps, control schedule, and prescriptions are jointly accepted.

Source: Researcher's construction (2025), condensed from the phenomenological analysis of the three dyads

Addressing the second objective, the textural and structural composites reveal that the lived experience of dyadic communication is essentially a transformation of anxiety into trust mediated by the doctor's empathic presence. Texturally, what the patients experienced was being welcomed without social or emotional distance: dr. X's warm, contemporary style made consultations feel friendly rather than frightening for child patients facing injections or infusions; dr. Y's calm smile, soft speech, and attentive body language signaled that every patient story was valid and meaningful; dr. Z's patience, consistency, and communicativeness turned Mrs. C's helplessness in facing an unexpected diagnosis into the courage to confront medical reality. Structurally, these experiences were formed within a field of tension between the doctors' professional pressures—dense schedules, efficiency demands, dual-layer communication with children and parents—and the patients' emotional conditions, and it was precisely the doctors' humanistic values that converted that tension into empathic, reflective, calming communication. Distinctively Indonesian features colored the experience: patients opened up gradually in accordance with cultural norms of politeness and religiosity; prayer accompanied medical decisions; and the paternalism that appeared was not domination but an expression of trust and respect that stabilized the dyadic relationship. The communication experience thus functioned therapeutically—not merely transmitting medical information but relieving the patient's emotional burden—so that, as in Mrs. C's final control session, the patient arrived at calm acceptance and gratitude, conscious of herself as a subject who gives meaning to her illness and recovery.

Addressing the third objective, the essence of the transcendental meaning of the dyadic relationship converges across the three pairs into a single pattern: the medical relationship is transformed into a whole human relationship. For dr. X and Mrs. S, the essence is equality and collaboration—the doctor acts not only as healer but as psychological and social facilitator, making the patient's family an equal partner, a concrete realization of *patient centered care*. For dr. Y and Mrs. B, the essence is the transformation of fear into trust and doubt into conviction, where health comes to mean not merely the absence of disease but the presence of inner calm and self-confidence to face treatment. For dr. Z and Mrs. C, the essence is the integration of the biological, psychological, social, and spiritual dimensions—empathic communication, respect for the patient's spirituality, and active participation in decision-making produced a more complete healing. Synthesized across cases, the transcendental meaning of the doctor–patient dyad is a humanizing practice grounded in empathy, trust, and equal collaboration, in which the doctor is no longer positioned solely as an authoritative figure but as a dialogic partner, and healing is measured not only by medical success but by the recovery of the patient's inner peace and dignity. This meaning, rooted in Indonesian cultural awareness and spirituality—religiosity, patience, courtesy, and respect—gives dyadic communication in Indonesia a character that distinguishes it from Western models, and it constitutes the foundation of the conceptual model discussed below.

The discussion answers the research problem by integrating the three essences—self-disclosure, the dyadic communication experience, and the transcendental meaning of the relationship—into a conceptual model of the development of doctor–patient communication in medical decision-making, presented in Figure 1. The model describes the relationship as a

staged but cyclical process. It begins with a pre-consultation stage in which the patient searches for doctor information via digital platforms; cautious patients verify a doctor's competence and reputation through hospital websites, social media, news articles, and testimonies before booking a first visit, which means trust formation now starts before any face-to-face encounter and makes digital professionalism part of modern medical communication. The first visit then enters Level 1 (Orientation), in which the doctor explores the illness through anamnesis and SOAP and suggests further examination or diagnosis, while the nervous, anxious patient answers only what is asked and critically assesses the doctor; when no further laboratory work is needed—or in subsequent sessions—the dyad moves into Level 2 (Affective Exploration), marked by affirmation, mutual trust, easy language, and detailed explanation of treatment options, benefits, and risks. Level 3 (Affective) is where decisions on medical actions and drug prescriptions emerge through a collaborative, democratic, emotionally close exchange, and Level 4 (Stable) closes the cycle with next steps to maintain health, a follow-up schedule, and prescriptions, communicated by an enthusiastic, sincere doctor to an optimistic, fully trusting, actively questioning patient. Each of the last two levels passes through a confirmation gate ("OK") signifying the patient's agreement, and both converge on decision making as the outcome of the relationship.

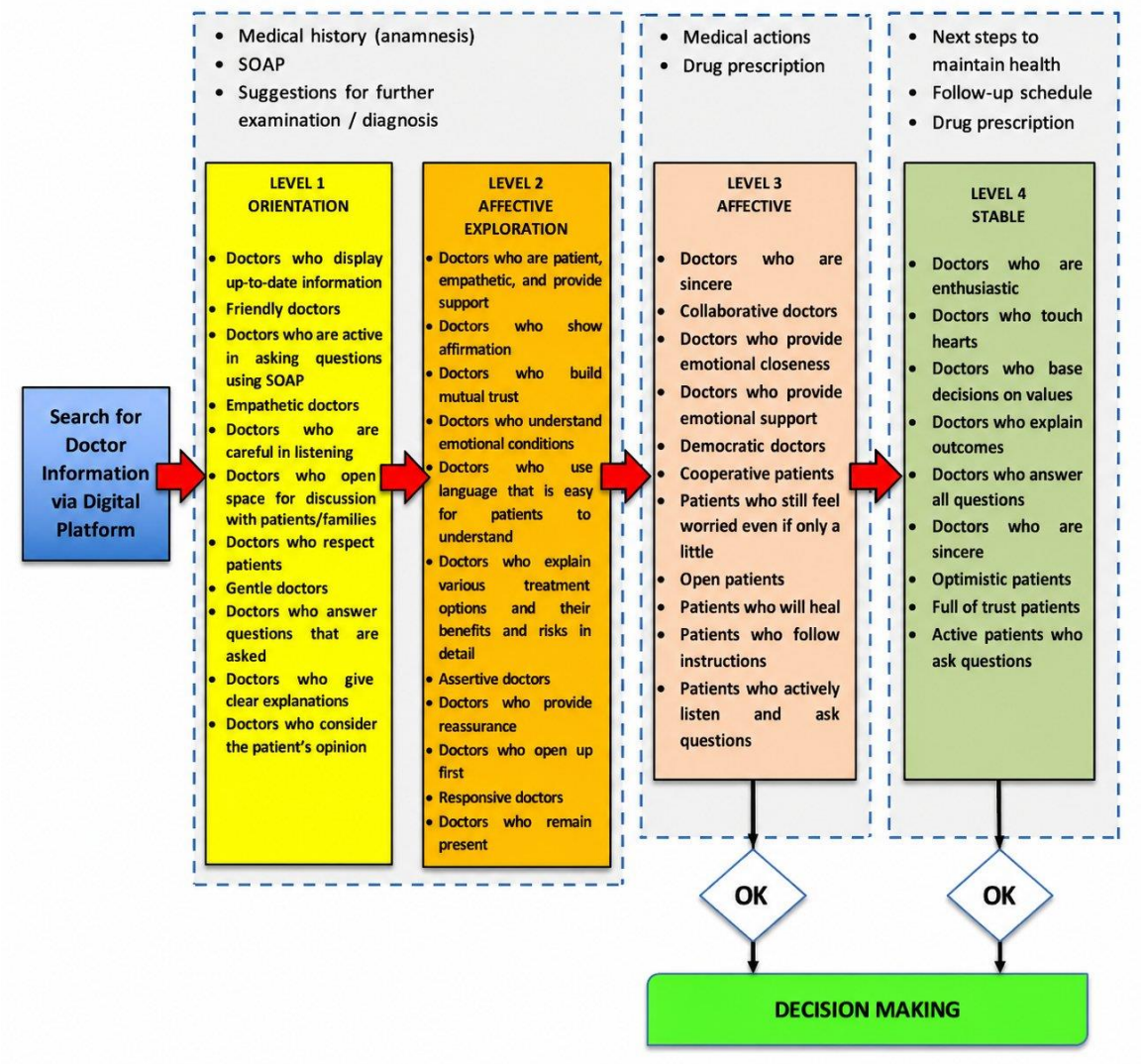

Figure 1. Dyadic Communication Model between Doctor and Patient in Medical Decision-Making
Source: Researcher's construction (2025)

Two analytical notes refine the model. First, the doctor is generally the prime mover of relational depth: doctors with strong communication skills dissolve the patient's defensive wall quickly, and the closer the relationship, the more accurate the resulting diagnosis and the more readily decisions are accepted—conversely, when communication fails, patients may refuse recommended actions, which in penetration terms is depenetration. Second, the decision itself rests on a dual foundation of medical diagnosis and communication, as mapped in Table 2. The interviews confirm this: doctors emphasized that a diagnosis is issued only after anamnesis in the SOAP process, followed where necessary by supporting examinations (laboratory, X-ray, CT scan, ultrasound), although an experienced doctor can sometimes diagnose from anamnesis alone with near certainty, as in the case of GERD (dr. Y, personal interview, 2024); when a patient initially refuses a diagnostic procedure, persuasive, hope-framed communication—explaining what the X-ray will show before and after successful therapy—regularly converts refusal into informed consent (dr. Z, personal interview, 2024). The assessment stage produces only a conclusion; it is at planning that decisions on treatment, actions, and even financial considerations are made, and the dialogue at this stage determines the success of healing.

Table 2. Basis for Determining Medical Decisions in the SOAP Stages

No	Stage	Target	Medical Diagnosis	Communication
1	S (Subjective)	Knowing what the patient feels through conversation about the complaint	–	✓
2	O (Objective)	Obtaining measurable medical evidence and the duration of the illness (physical findings, blood tests, X-ray, etc.)	✓	✓
3	A (Assessment)	Making a clinical judgment by linking the various sets of data into a conclusion	✓	✓
4	P (Planning)	Deciding on treatment/medical action and financial considerations; what is decided here determines the success of healing	✓	✓

Source: Researcher's construction (2025)

Beyond the dyad itself, the analysis identified contextual factors that condition the decision-making process. The medical code of ethics requires the doctor to maintain empathy without sympathy—feeling with the patient's illness without personal entanglement—so that the relationship remains fair, professional, and free of preferential treatment. Hospital management does not regulate the doctor's communicative behavior but provides standard operating procedures and a tiered competence system (beginner, intermediate, advanced) in which doctors may refer patients to colleagues with more advanced communication skills; consultations generally run about fifteen minutes per patient without doctors perceiving this as managerial pressure. Peer influence and clinical basic skill matter as well, since a doctor without supporting diagnostic equipment, or facing a patient with budget constraints, must rely on strong fundamental skills honed by case experience. Finally, in Indonesia's collectivistic culture, the family is an inseparable communication partner: medical decisions—such as Mrs. C's surgery or decisions for child and pregnant patients—are typically reached through deliberation with parents, spouses, and relatives, so effective medical communication must involve the family without negating the patient's individual autonomy.

Placed in theoretical dialogue, the findings extend the four interpersonal theories framing this study. Against Social Penetration Theory, relationship development in the medical context did not follow strictly linear stages: the trajectory proved dynamic, contextual, and spiral, capable of repetition or regression depending on the patient's emotional condition—each new

diagnosis or procedure could return the dyad to earlier caution. Against Social Exchange Theory, the doctor–patient relationship cannot be fully explained by rational cost–benefit calculation, because empathy, compassion, and moral responsibility operate as non-transactional forms of reciprocity in which trust and humanity are themselves the reward. Against Relational Dialectics Theory, the relationship is saturated with tensions—authority versus participation, privacy versus openness, emotionality versus professionalism—and it is precisely the doctor's empathic negotiation of these tensions that produces a healthy therapeutic relationship (Baxter & Montgomery, 1998). Against Uncertainty Reduction Theory, uncertainty is not confined to the initial stage but recurs at every session, since each examination result, diagnostic change, or new medical decision generates fresh uncertainty demanding renewed empathic, reflective communication. The findings also strengthen the principles of *patient centered communication* (Littlejohn, Foss, & Oetzel, 2021) and the concept of shared decision-making, demonstrating empirically that medical decisions are the product of collaborative dialogue blending rational, emotional, and spiritual considerations rather than one-way instruction.

Synthesized inductively, the study yields three forms of novelty. Theoretically, it expands the self-disclosure stage of Social Penetration Theory with the cultural and spiritual nuances of Indonesian society—openness that takes the form of prayer, empathy, and respect—and enriches *patient centered communication* and the biopsychosocial model into a biopsychosocial–spiritual–cultural model better suited to Indonesian clinical reality. Empirically, it documents new findings on how generation, emotion, social media, and the role of the family shape the dynamics of doctor–patient communication. Practically, it offers the dyadic communication model in Figure 1—a *patient-centeredness*-based model that is adaptive across generations and treats trust as a staged process in the therapeutic relationship. Taken together, the results answer all three research objectives: the communication relationship develops through staged self-disclosure driven by the patient's active involvement; the lived communication experience transforms anxiety into trust through empathic presence; and the transcendental meaning of the dyad grounds *patient centered care* and the biopsychosocial approach in the recognition that true healing occurs not only through medical action but through a humane, dialogic relationship that restores the patient's dignity in body, mind, and soul.

These results carry practical implications consistent with the discussion above. The effectiveness of medical service depends not only on the doctor's technical competence but on the capacity to be empathically present, listen actively, and build trust; humanistic dyadic relationships demonstrably increase patient satisfaction, reduce anxiety, and strengthen patient engagement. Hospitals can therefore use the model as material for evaluating the implementation of patient-centeredness, for designing communication training that includes sensitivity to nonverbal cues and emotional experience, for developing cross-generational and cross-cultural adaptive communication in a multicultural society, and for cultivating digital professionalism, given that patient trust now begins to form on digital platforms before the first consultation ever takes place.

CONCLUSION

This study set out to explore and deeply understand the development of the doctor–patient communication relationship in health consultations, and its conclusions answer the three research objectives directly. First, the relationship does not form instantly but develops in stages through the patient's active involvement, moving from formal, cautious interaction toward open, collaborative partnership; the trajectory follows the penetration stages of orientation, affective exploration, affective, and stable, begins even before the first encounter

through digital information-seeking, and is shaped by emotion, length of relationship, age and generational differences, and cultural values, with self-disclosure in the Indonesian context extending beyond personal information to include prayer, empathy, and respect. Second, the lived communication experience is essentially therapeutic: it transforms patient anxiety into trust through the doctor's empathic presence, simple language, and attentive nonverbal behavior, and this relational quality supports the accuracy of diagnosis and the acceptance of medical decisions reached through the dual foundation of medical diagnosis and communication within the SOAP process. Third, the transcendental meaning of the dyadic relationship lies in its humanizing character—a relation of equal, dialogic partnership in which healing is measured not only by clinical success but by the recovery of the patient's inner peace and dignity—providing an experiential foundation for *patient centered care* and the biopsychosocial approach in clinical practice.

The study advances communication scholarship in three ways. Theoretically, it extends Social Penetration Theory by demonstrating that relational development in medical settings is dynamic, contextual, and spiral rather than strictly linear, and it enriches the self-disclosure construct—and, more broadly, *patient centered communication* and the biopsychosocial model—with the cultural, religious, and spiritual dimensions of Indonesian society, yielding a biopsychosocial–spiritual–cultural perspective in which even apparent paternalism is reinterpreted as an expression of trust and respect. Empirically, it documents how generation, emotion, digital media, and the family as a deliberative partner shape dyadic medical communication in a collectivistic society. Practically, it offers a four-level dyadic communication model culminating in shared decision-making that hospitals can use for evaluating patient-centeredness, designing holistic communication training sensitive to nonverbal and emotional cues, and cultivating digital professionalism, since patient trust now begins to form on digital platforms before the first consultation.

As a transcendental phenomenological study of three doctor–patient dyads in one Indonesian hospital, the findings aim at depth of meaning and transferability rather than statistical generalization. Future research is encouraged to test the proposed model in relation to patient satisfaction and loyalty following the implementation of patient-centered communication, to examine depenetration when communication fails, and to extend the inquiry to other health professionals and service contexts. Within those boundaries, the study affirms its central claim: clinical communication cannot be understood merely as an exchange of medical information—it is a humane encounter in which professional competence and empathy together restore the whole person, in body, mind, and soul.

REFERENCES

Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships*. Holt, Rinehart and Winston.

Amal, S. (2019). Metode bracketing Edmund Husserl. *Dialektika: Jurnal Pemikiran Islam dan Ilmu Sosial, 12*(1), 77–87.

Australian Commission on Safety and Quality in Health Care. (2010). *Patient-centred care: Improving quality and safety by focusing care on patients and consumers*. ACSQHC.

Baxter, L. A., & Montgomery, B. M. (1998). *Relating: Dialogues and dialectics*. Guilford Press.

Bertakis, K. D., Roter, D., & Putnam, S. M. (1991). The relationship of physician medical interview style to patient satisfaction. *Journal of Family Practice, 32*(2), 175–181.

Bolton, D., & Gillett, G. (2019). *The biopsychosocial model of health and disease: New philosophical and scientific developments*. Palgrave Macmillan.

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine, 2*(6), 576–582.

Canadian Medical Association. (2007). *7th annual national report card on health care*. CMA.

Chewning, B., Bylund, C. L., Shah, B., Arora, N. K., Gueguen, J. A., & Makoul, G. (2012). Patient preferences for shared decisions: A systematic review. *Patient Education and Counseling, 86*(1), 9–18.

Coulter, A. (2006). *Engaging patients in their healthcare*. Picker Institute Europe.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Sage.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Elwyn, G., Edwards, A., & Kinnersley, P. (1999). Shared decision-making in primary care: The neglected second half of the consultation. *British Journal of General Practice, 49*(443), 477–482.

Epstein, R. M., & Street, R. L., Jr. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. National Cancer Institute.

Epstein, R. M., & Street, R. L., Jr. (2011). The values and value of patient-centered care. *Annals of Family Medicine, 9*(2), 100–103.

Fortes, S., Villano, L. A. B., & Lopes, C. S. (2008). Nosological profile and prevalence of common mental disorders of patients seen at the Family Health Program units in Petrópolis, Rio de Janeiro. *Revista Brasileira de Psiquiatria, 30*(1), 32–37.

Giorgi, B. (2006). Can an empirical psychology be drawn from Husserl's phenomenology? In P. D. Ashworth & M. C. Chung (Eds.), *Phenomenology and psychological science* (pp. 69–88). Springer.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 42–55.

Harrington, N. G. (2015). *Health communication: Theory, method, and application*. Routledge.

Hepburn, A., & Bolden, G. B. (2012). The conversation analytic approach to transcription. In J. Sidnell & T. Stivers (Eds.), *The handbook of conversation analysis* (pp. 57–76). Wiley-Blackwell.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology* (D. Carr, Trans.). Northwestern University Press.

Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen. (2011). *Patienteninformation: Wunsch und Wirklichkeit*. IQWiG.

Ishikawa, H., Hashimoto, H., & Kiuchi, T. (2013). The evolving concept of "patient-centeredness" in patient–physician communication research. *Social Science & Medicine, 96*, 147–153.

Jaroudi, S., & Payne, J. D. (2019). Remembering Lawrence Weed: A pioneer of the SOAP note. *Academic Medicine, 94*(1), 11.

KODEKI. (2012). *Kode etik kedokteran Indonesia*. Pengurus Besar Ikatan Dokter Indonesia.

Kuswarno, E. (2009). *Fenomenologi: Metodologi penelitian komunikasi*. Widya Padjadjaran.

Laine, C., & Davidoff, F. (1996). Patient-centered medicine: A professional evolution. *JAMA, 275*(2), 152–156.

Larsson, I. E., Sahlsten, M. J. M., Segesten, K., & Plos, K. A. E. (2011). Patients' perceptions of nurses' behaviour that influence patient participation in nursing care: A critical incident study. *Nursing Research and Practice, 2011*, 534060.

Littlejohn, S. W., Foss, K. A., & Oetzel, J. G. (2021). *Theories of human communication* (12th ed.). Waveland Press.

Mendes, I. A. C., Ventura, C., Trevizan, M. A., & Marchi-Alves, L. M. (2016). Communication in health: A necessity for care. *Texto & Contexto – Enfermagem, 25*(3), e20150316.

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Ogundele, O. A., & Ojo, O. O. (2018). Patients' perception of doctors' communication skills in a Nigerian tertiary healthcare facility. *Journal of Clinical Sciences, 15*(1), 8–12.

Rao, S., & Rao, S. (2017). Doctor–patient communication in a hospital: A cross-sectional study in a tertiary care hospital in South India. *Journal of Clinical and Diagnostic Research, 11*(8), 1–5.

Rise, M. B., Solbjør, M., Lara, M. C., Westerlund, H., Grimstad, H., & Steinsbekk, A. (2013). Same description, different values: How service users and providers define patient and public involvement in health care. *Health Expectations, 16*(3), 266–276.

Roter, D. L., & Hall, J. A. (2006). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits* (2nd ed.). Praeger.

Roter, D. L., Hall, J. A., & Aoki, Y. (2002). Physician gender effects in medical communication: A meta-analytic review. *JAMA, 288*(6), 756–764.

Sarantakos, S. (2013). *Social research* (4th ed.). Palgrave Macmillan.

Setiawan, A. R. (2019). Analisis kepuasan pasien terhadap komunikasi dokter di Puskesmas Kota Yogyakarta. *Jurnal Kesehatan Masyarakat, 15*(2), 178–185.

Stewart, M. (2001). Towards a global definition of patient centred care. *BMJ, 322*(7284), 444–445.

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L., & Freeman, T. R. (2014). *Patient-centered medicine: Transforming the clinical method* (3rd ed.). Radcliffe Publishing.

Sugiyono. (2020). *Metode penelitian kualitatif dan R&D*. Alfabeta.

Tongue, J. R., Epps, H. R., & Forese, L. L. (2005). Communication skills for patient-centered care. *Journal of Bone and Joint Surgery, 87*(3), 652–658.