

Mindfulness As A Human Capital Capability For Sustainable Service Entrepreneurship: Evidence From Healthcare Enterprises In India



Dr. Viswanath Bandi^{1*}, Mr. A. Arjun², Prof(Dr) Anand Bethapudi³

^{1*}Associate Professor, KLEF, KL University Business School, Hyderabad, viswanathbandi1391977@gmail.com,
Orcid ID: 0000-0001-7622-2708

²Department of MBA, 2311510005@klh.edu.in

³Dean, KLEF, KL University Business School, Hyderabad, dean.gbs@klh.edu.in

Abstract: Healthcare enterprises in emerging economies operate under sustained service pressure, where workforce well-being and service quality are closely interrelated. In public healthcare settings, physicians often experience high workloads that contribute to burnout, which may influence service interactions and patient perceptions of care. Prior research has identified mindfulness as a capability that supports attention, emotional regulation, and engagement; however, empirical evidence linking physician mindfulness to service interaction quality within Indian healthcare enterprises remains limited. This study examines mindfulness as a human capital capability and its relationship with patient-perceived quality of care in public healthcare in India. Data were collected from 50 specialist gynecologists and 50 patient caregivers at a government hospital using convenience sampling. Physician mindfulness was measured using the Five-Facet Mindfulness Questionnaire, which captures observing, describing, acting with awareness, non-judgment, and non-reactivity. Patient-perceived service interaction quality was assessed using the general communication subscale of the Personal Processes of Care Instrument. The statistical analyses included reliability testing, correlation analysis, and multiple regression. The findings indicate that the proposed model explains 72.4% of the variance in patient-perceived-care quality. The dimensions of experience and non-reactivity were significantly associated with perceived service quality, whereas acting with awareness showed a significant inverse association. Physician experience was not significantly associated with mindfulness levels. Overall, the results highlight mindfulness as a human capital capability that shapes service interactions and contributes to sustainable service performance in healthcare enterprises.

KEY WORDS: Government hospital, Mindfulness, Physicians, Satisfaction.

Introduction: Service-based enterprises are involved in the major sector of economic activity in the emerging economies of Asia, especially in nations like India, where small and medium-sized enterprises (SMEs) prevail in the service sector. In the case of these businesses, sustainability goes beyond environmental responsibility to include economic sustainability, labour stability, and the capability of providing consistent service in the long term (1,2). Studies concerning SMEs demonstrate that in service-related situations, human capabilities are the key to long-term performance because, with the help of interaction, experience, and trust, value is created not only using physical assets but also due to interaction, experience, and trust (1,3).

Healthcare enterprises are among the most competitive service entrepreneurship. In India, the conditions under which healthcare organizations work are characterized by the high demand for service, low quantity of resources, and growing expectations of the quality of services provided and their accountability. In particular, private hospitals and medium-sized healthcare businesses must be efficient, ethically responsible, and address ongoing operational challenges. Simultaneously, healthcare organizations are becoming increasingly active in an environment of innovation that demands frankness, cooperation, and flexibility, particularly in times of

discontinuity (4). Indian hospital evidence indicates that the orientation towards innovation of services and open innovation practices are related to the enhanced performance of the organization, which underlines the significance of internal capabilities in the preservation of healthcare businesses (5,6).

One of the unending problems in healthcare service businesses is workforce burnout. Burnout is often defined as a state of emotional exhaustion, work detachment, and professional ineffectiveness due to the long-term experience of work-related stress (14). Empirical research has found a connection between burnout in healthcare professionals with less work engagement, lower quality of services provided, and increased turnover desires, which threaten organizational stability (15,16). Therefore, burnout is a personal issue and a structural risk to service continuity and long-term functioning of high-contact service settings, as perceived in an enterprise-wide manner (17,18).

In this respect, the topic of mindfulness has been gaining momentum as a human ability that can aid people in their efforts to deal with long-term workloads. Mindfulness has been mainly perceived as the act of giving attention to current experiences with a sense of openness and non-judgmentality. While early literature focused on the clinical outcomes of mindfulness, more recent studies in the

organizational context view mindfulness as a work-related ability that facilitates attention, emotional control, and engagement (7,8). These attributes are more applicable in service-based businesses, where employees are expected to handle emotional pressures and deliver service standards.

Organizational research has provided empirical evidence indicating that mindfulness is related to better work engagement, job performance, and reduced stress levels among employees and managers (9,10). Individuals with higher mindfulness become more attentive during communication and would react to stressful circumstances more easily, which can lead to more stable service provision (11). From a sustainability perspective, these attributes facilitate the creation of a strong workforce that can perform even under constant pressure (8). Mindfulness has also been examined in relation to entrepreneurship and sustainability-oriented decision making. Studies on social and sustainable entrepreneurship indicate that mindfulness may help individuals balance economic objectives with social and ethical considerations, particularly in contexts involving multiple stakeholders and competing demands (12,13). This implies that the concept of mindfulness can be applied not only on an individual scale but also in the context of defining how service enterprises can coordinate operational practices with the larger objectives of sustainability.

In healthcare businesses, interactions between service professionals and service recipients are closely related to service performance. Previous studies have indicated that active listening, consideration, and feelings during service interactions can lead to trust and favourable ratings of service quality (25,26). Mindfulness can facilitate this interactional functioning by limiting reactive behavior and promoting more attention when providing services, thereby increasing the uniformity of the service experience (20,24).

Although the topic of mindfulness in organizational research is increasingly gaining interest, there is only limited empirical research to test the relationship between mindfulness and sustainable service performance in healthcare businesses, especially in the new Asian market. The available literature focuses on individual well-being or clinical outcomes rather than enterprise-level outcomes, including service sustainability and organizational performance (21,22). Further research is required on how mindfulness can be a human capability in service organizations to enhance knowledge in the Indian context, where healthcare businesses experience relentless demands and limited resources.

This study investigates the concept of mindfulness as a human capital competency and establishes the connection between the concept and sustainable service performance in Indian healthcare businesses.

This study aims to provide an understanding of how mindfulness in service professionals and its service effectiveness are intertwined in a high-demand service setting by concentrating on service-recipient perceptions of service interactions.

Review of Literature: Burnout is the issue which has been commonly identified as an issue in service-based industries, especially in healthcare where experts are asked to cope with emotional, intellectual, and social pressures which are long term in nature. Burnout is traditionally defined as emotional fatigue, depersonalization, and lack of professional competence due to long-term working pressure (14). Burnout in healthcare businesses has been associated with lower work engagement, lower service quality, absenteeism, and worsened turnover intentions, which adversely impact organizational stability and long-term performance (15,16). These findings show that the problem of burnout is not a personal issue of well-being because it is a more general organizational problem that endangers the sustainability of service-based businesses that are now in high demand (17,18).

Studies also indicate that burnout compromises attentiveness, emotional presence, and responsiveness in service encounters, which are essential elements of service in healthcare facilities (19). Given that the production of healthcare services is mostly based on repeated communication between professionals and service users, the less cognitive and emotional involvement of the service-delivering parties may directly affect service performance. This interconnectedness of workforce well-being and service performance implies the significance of building the capability of human capital that can promote long-term engagement and the successful provision of services to the enterprise in the field of healthcare.

To overcome these problems, mindfulness has become a topic that can attract increasing attention as a power that can help people cope better with stressful work environments. Generally, mindfulness is the tendency to be attentive to current experiences without being fixated on them and too judgmental (22). Although previous studies have been mainly concerned with clinical and psychological outcomes, more recent studies in organizational settings have theorized mindfulness as a work-related capacity that facilitates attentional control, emotional regulation, and engagement (7,8). These traits are especially applicable to service-based businesses, where professionals must handle emotional needs and simultaneously provide high-quality services regularly.

Organizational research shows that empirical studies have a positive relationship between mindfulness and work engagement, job performance, and reduced stress levels among employees and managers (9,10). Those who are

more mindful are likely to be alert throughout communication, better control their emotions, and react without panic to difficult circumstances, which facilitates the provision of reliable and consistent services (11). In terms of sustainability, these qualities can help create a strong workforce that can sustain output in the long run, regardless of continuous demands (8).

Mindfulness has been defined as a multidimensional construct and is said to consist of experiencing, describing, acting mindfully, non-judgmental attitude, and non-reactivity to internal events. Experience of observation and description leads to increased awareness and clarity, which are essential in the interpretation of service situations and responses to situations in complex environments (7,10). Being mindful allows professionals to give their full attention to tasks and service contact, minimize errors, and facilitate uniform service delivery (9). Non-judgment and non-reactivity allow people to manage emotional reactions and prevent automatic/reactive behavior when they face a difficult service experience, which is especially crucial in high-stress healthcare facilities (11).

The quality of service in the healthcare business is strongly associated with the type of relationship between the professionals and recipients of the service. Existing research suggests that sensitive communication, emotional presence, and responsiveness throughout service interactions are sources of trust, satisfaction, and good ratings of service quality (25,26). The above interactive features are the key to service-oriented value generation and sustainability of enterprises. Mindfulness can aid these mechanisms by contributing to improved awareness and emotional regulation, which increases the reliability and consistency of service interactions (20,24).

Further to the role of a person in performance, mindfulness has also been explored with respect to entrepreneurship and sustainability-based decision making. Research on social and sustainable entrepreneurship indicates that mindfulness can help people pursue economic goals and social and ethical aspects in situations with numerous stakeholders and conflicting needs (12,13). This ability applies to healthcare companies that should balance operational effectiveness with ethical accountability and long-term sustainability.

Innovation-oriented healthcare enterprises are becoming increasingly functional under conditions of disruption, which demand flexibility, teamwork, and accessibility to novel operations (4). Indian

hospital evidence indicates that service innovation orientation and open innovation practices play a major role in organizational performance, with the need for internal capabilities to maintain healthcare enterprises (5,6). Mindfulness can help professionals handle complexity, preserve the quality of services, and adjust to the new demands of the organization in such environments.

Despite the fact that the available literature supports the assertion that mindfulness can boost personal well-being and work performance, scarce empirical research has investigated the issue of mindfulness in sustainable service delivery among healthcare businesses in developing economies. Much of the literature focuses on clinical or psychological outcomes, and little is said about enterprise-level implications, including service sustainability and performance (21,22). The Indian situation, where healthcare organizations are persistently challenged by demand and resource limitations, requires additional studies to comprehend how mindfulness can be considered a human capital capability of service organizations.

This study is devoted to the way in which mindfulness among physician's manifests in service interactions in government healthcare enterprises in the eyes of service receivers. In particular, it investigates parents' perceptions of physicians' attentiveness, the clarity of their communications regarding diagnosis and dosage, and the quality of interactions with them during appointments. According to prior studies, mindfulness helps attentional focus, emotional regulation, and non-reactive engagement, which are vital in providing services effectively to people in a high-contact service environment, including healthcare (7,22,25). Thus, doctors who portray greater degrees of mindfulness are anticipated to be more inclined to offer superior interpersonal care, which would lead to greater patient care quality.

Using the available literature, it is possible to suggest a conceptual framework that depicts the interconnection between the main dimensions of mindfulness, namely observing, describing, acting with awareness, non-judgment, and non-reactivity, and the quality of patient care, which is shown in Figure 1. The notion of patient care quality is introduced as a measure of sustainability in the service delivery of healthcare firms. It is based on human capital theory and conceptually related to service-dominant logic, making mindfulness an intangible ability that determines the quality-of-service interaction.

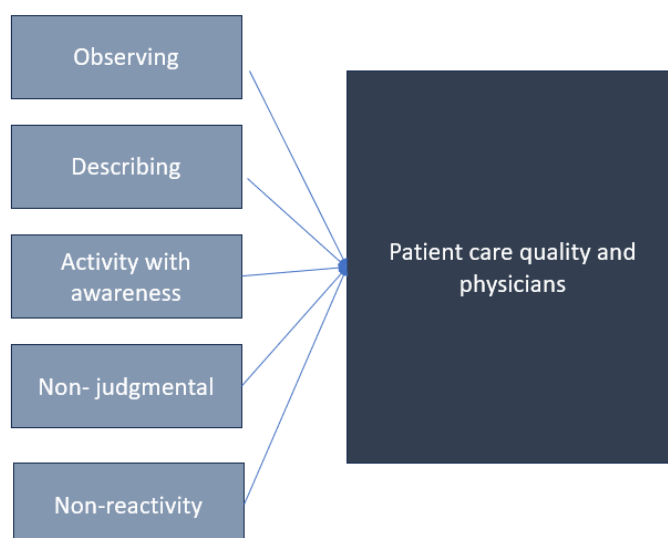


Figure1: Conceptual framework illustrating the relationship between dimensions of mindfulness and patient care quality in healthcare enterprises.

Methodology: This study was conducted in a public-sector tertiary government hospital in Hyderabad, Telangana, India. The hospital was chosen based on its high patient flow and the existence of specialist physicians who offer constant service delivery in a resource-limited environment. Specialized gynecologists were studied because they have prolonged contact with patients in their clinical work and repeated encounters with the service. Gynecologists were selected because their practice involves high intensity, frequency, and emotional sensitivity of service interactions; thus, they provide an ideal setting in which mindfulness as a service capability can be studied. Fifty specialist gynecologists were involved in the study. Convenience sampling was used to select the participants based on the fact that they were available and willing to take part in the data collection period. Although convenient sampling restricts generalization, it is widely used in exploratory studies conducted in operational service settings, such as government healthcare facilities. In addition to physicians, the study incorporated 50 patient caregivers to help the researcher capture service recipient perceptions of physician interaction quality. The caregivers were chosen

because they were directly engaged in consultations and treatment discussions and could therefore assess the communication and other interpersonal behaviors of the physicians. The physician-patient interaction as perceived by the recipients of the service was the unit of analysis in this study. Physician experience was also used as a control variable to investigate whether mindfulness-related capabilities were related to tenure in the profession. Caregivers were surveyed alone following the consultations to minimize the risk of bias in their responses and were unaware of the physicians' mindfulness scores.

Physician mindfulness was assessed using the Five Facet Mindfulness Questionnaire (FFMQ), which consists of 39 items measuring five dimensions of mindfulness: observing, describing, acting with awareness, non-judgment, and non-reactivity. The FFMQ was selected because of its multidimensional structure and widespread use in occupational and organizational research to assess mindfulness-related capabilities. Responses were recorded on a five-point Likert scale ranging from 1 ("very rarely true") to 5 ("almost always true"). The questionnaire items corresponding to each mindfulness dimension are listed in Table 1.1.

Table 1.1: FFMQ - Questionnaire break-up with parameters.

| Variable | Observing | Describing | Acting with awareness | Non-judgemental | Non-reactivity |
|----------|-----------------------|-----------------------|-----------------------|------------------------|--------------------|
| Q. No | 1,6,11,15,20,26,31,36 | 2,7,12,16,22,27,32,37 | 5,8,13,18,23,28,34,38 | 3,10,14,17,25,30,35,39 | 4,9,19,21,24,29,33 |

Patient-perceived quality of physician interaction was assessed using the general communication subscale of the Personal Processes of Care (PPC)

instrument. This instrument captures service recipients' perceptions of physician communication behavior, including hurried communication,

elicitation of concerns, explanation of results and medication, decision-making involvement, interpersonal style, and respectfulness. Responses were recorded on a five-point Likert scale ranging from 1 ("never") to 5 ("always"). The PPC items were grouped under their respective dimensions to form

an aggregate measure of patient care quality (Table 1.2). In this study, PPC scores were treated as the dependent variable representing patient-perceived service interaction quality, and mindfulness dimensions served as independent variables.

Table 1.2: PPC Instrument Questions break-up

| Variable | Hurried communication | Elicited Concerned Responses | Explained Results and Medication | Decision Making | Interpersonal style, compassionate respectful | Discrimination | Disrespectful staff |
|----------|-----------------------|------------------------------|----------------------------------|-----------------|---|----------------|---------------------|
| Q. No | 1,2,3,19,20 | 21,22,23 | 24,25,26,27 | 28,29,30,31 | 32/33/34/35 | 36,37,38,39 | 40,41,42,43 |

In the analysis process, the internal consistency and reliability of the measurement scales were evaluated using Cronbach's alpha. Descriptive statistical analysis was performed to generalize the sample features and test the distribution and central tendencies of the research variables. Correlation analysis was then performed to identify relationships among mindfulness dimensions at significance levels of $p < 0.05$ and $p < 0.01$. Multiple regression analysis was subsequently employed to examine the extent to which the dimensions of mindfulness explained the variation in patient-perceived care quality and to test the proposed research framework. All statistical analyses were performed using standard statistical software. Ethical considerations were taken into account before data collection. All participating physicians and patient caregivers were informed about the purpose of the study, and informed consent was

obtained before the questionnaires were administered. It was done voluntarily, and the anonymity of the responses was guaranteed.

Results:

The demographic traits of the sample of physicians were summarized using descriptive statistics. As shown in Figure 2, 60% of the participating gynecologists were men and 40% were women. Figure 3 illustrates the professional experience profile of the respondents, indicating a diverse distribution across different experience levels. Approximately 20% of the gynecologists had up to five years of experience, 30% had up to ten years of experience, another 30% had between eleven and fifteen years of experience, 10% had between sixteen and twenty years of experience, and 5% had more than twenty years of experience.

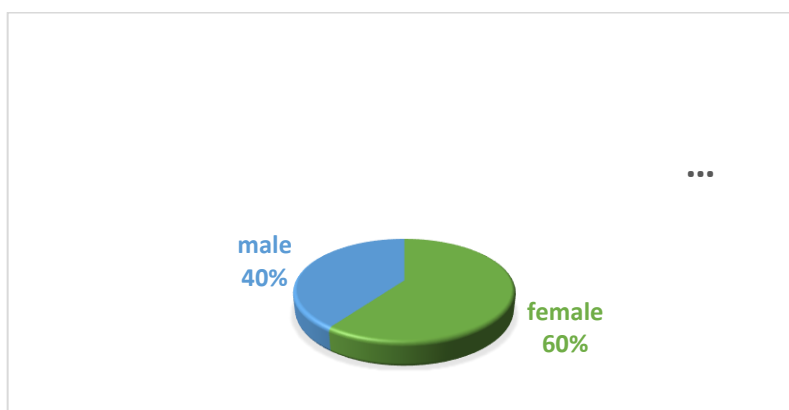


Figure 2: Gynaecologist's gender profile

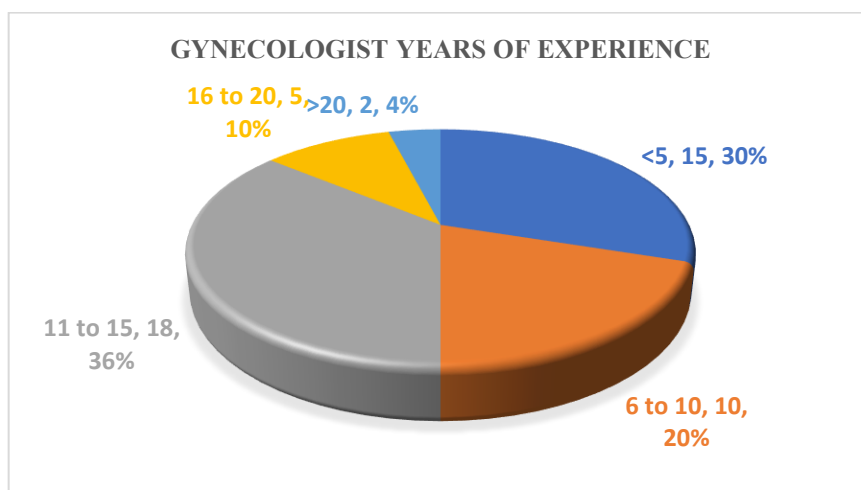


Figure 3: Gynaecologist's experience profile

Cronbach's alpha was used to determine the internal consistency and reliability of the mindfulness measurement.

Table 2: Internal consistency of Mindfulness Scale

| Serial No | Sample Details | Cronbach alpha |
|-----------|---|----------------|
| 1 | Gynaecologist Responses (FFMQ scale components) | 0.81 |

As shown in Table 2, the overall Cronbach's alpha value for the FFMQ scale was 0.81, indicating acceptable internal consistency for subsequent statistical analyses.

Table 3. Correlation Analysis between Mindfulness Dimensions

| Observing | Describing | Acting with Awareness | Non - Judgemental | Non-Reactive |
|-----------|------------|-----------------------|-------------------|--------------|
| 1 | | | | |
| 0.12151 | 1 | | | |
| 0.17644 | 0.078 | 1 | | |
| -0.06623 | 0.063 | 0.2104 | 1 | |
| 0.07557 | 0.2783 | 0.1847 | 0.2046 | 1 |

Table 4: Correlation significance along with alpha and critical R values

| Significance Level | Alpha (α) | Critical r Value |
|--------------------|--------------------|------------------|
| *P<0.05 | 0.0500 | 0.165651196 |
| **P<0.01 | 0.0100 | 0.214698452 |

The relationships between the five dimensions of mindfulness were examined using correlation analysis. According to the findings, the dimensions are connected but are independent elements of mindfulness. The correlation coefficients among observing, describing, acting with awareness, non-

judgment, and non-reactivity are presented in Table 3, and the corresponding significance levels and critical values are reported in Table 4. Several correlations among the mindfulness dimensions were statistically significant at $p < 0.05$ and $p < 0.01$ levels.

Table 5. Regression Model Summary

| Regression Statistics | |
|-----------------------|---------|
| Multiple R | 0.8513 |
| R Square | 0.7247 |
| Adjusted R Square | 0.5870 |
| Standard Error | 0.0951 |
| Observations | 50.0000 |

As shown in Table 5, the regression model has a strong explanatory power. The coefficient of determination (R^2) was 0.724, indicating that 72.4% of the variance in patient-perceived care quality was

explained by mindfulness dimensions. The adjusted R^2 value of 0.587 suggests a robust model fit after accounting for the number of the predictors.

Table 6: ANOVA test and level of significance

| ANOVA | | | | | |
|------------|-----------|-----------|-------------|-------------|-----------------------|
| | <i>df</i> | <i>SS</i> | <i>MS</i> | <i>F</i> | <i>Significance F</i> |
| Regression | 8 | 0.381 | 0.047622257 | 5.264446377 | 0.002355907 |
| Residual | 41 | 0.1447 | 0.009046014 | | |
| Total | 49 | 0.5257 | | | |

The overall significance of the regression model was assessed using ANOVA. As presented in Table 6, the F-statistic was statistically significant ($p = 0.0023$), indicating that the model provided a meaningful explanation of patient-perceived quality of care. Separate regression models were estimated to examine the individual contributions of physician

experience and each mindfulness dimension to patient-perceived care quality.

To further examine the individual contribution of each mindfulness dimension, separate regression-based t-tests were performed. Hypothesis testing was conducted using t-tests to examine the impact of individual mindfulness dimensions on the quality of patient-perceived care.

Table 7: Hypothesis testing of physicians' Experience on Mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|-----------|---------------------|-----------|---------------|----------------|------------------|------------------|
| Intercept | 3.11487 | 0.3518 | 8.854053297 | 0.0001 | 2.3690 | 3.8606 |
| EXP | -0.0342 | 0.0183 | -1.8969 | 0.0880 | -0.0742 | 0.00571 |

As shown in Table 7, physicians' experience did not have a statistically significant effect on mindfulness

($p = 0.088$). Therefore, the null hypothesis was not rejected.

Table 8: Hypothesis testing of physicians' Nature of Observation on Mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|-----------|---------------------|-----------|---------------|----------------|------------------|------------------|
| Intercept | 3.11487 | 0.3518 | 8.8540 | 0.0001 | 2.3690 | 3.8606 |
| Observing | 0.0661 | 0.0452 | 1.4622 | 0.1630 | -0.0297 | 0.1620 |

The observing dimension was not demonstrate a statistically significantly associated with patient-perceived care quality ($p = 0.163$; Table P).

Table 9: Hypothesis testing of physician's Nature of describing on Mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|------------|---------------------|-----------|---------------|----------------|------------------|------------------|
| Intercept | 3.11487 | 0.3518 | 8.8540 | 0.0001 | 2.3690 | 3.8606 |
| Describing | 0.2020 | 0.0567 | 3.5642 | 0.0025 | 0.0818 | 0.3222 |

As shown in Table 9, the describing dimension exhibited a statistically significant relationship with patient-perceived care quality ($p = 0.002$).

Table 10: Hypothesis testing of physician's acting with awareness on Mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|----------------------------|---------------------|---------------|---------------|----------------|------------------|------------------|
| <i>Intercept</i> | <i>3.11487</i> | <i>0.3518</i> | <i>8.85</i> | <i>0.0001</i> | <i>2.369</i> | <i>3.860</i> |
| <i>Acting in Awareness</i> | <i>-0.2063</i> | <i>0.0524</i> | <i>-3.93</i> | <i>0.0011</i> | <i>-0.317</i> | <i>-0.095</i> |

The Acting with Awareness dimension showed a statistically significant association with patient-perceived care quality ($p = 0.001$), as reported in Table 10. Negative coefficients indicate an inverse

statistical association between these dimensions and patient-perceived care quality within the studied context.

Table 11: Hypothesis testing of physicians' nature of being non-judgemental on mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|-----------------|---------------------|-----------|---------------|----------------|------------------|------------------|
| Intercept | 3.11487 | 0.3518 | 8.854 | 0.0001 | 2.369 | 3.860 |
| Non-Judgemental | -0.0196 | 0.047 | -0.415 | 0.683 | -0.120 | 0.0807 |

Table 11 indicates that the non-judgment dimension was not statistically significant ($p = 0.683$), indicating

no measurable effect on patient-perceived care quality.

Table 12: Hypothesis testing of physician's non-reactive nature of Mindfulness

| | <i>Coefficients</i> | <i>SE</i> | <i>t Stat</i> | <i>P-value</i> | <i>Lower 95%</i> | <i>Upper 95%</i> |
|--------------|---------------------|-----------|---------------|----------------|------------------|------------------|
| Intercept | 3.114 | 0.351 | 8.85 | 0.0001 | 2.369 | 3.8606 |
| Non-Reactive | -0.113 | 0.048 | -2.31 | 0.034 | -0.216 | -0.093 |

As presented in Table 12, non-reactivity was significantly associated with patient-perceived care quality ($p = 0.034$). Negative coefficients indicate an

inverse statistical association between these dimensions and patient-perceived care quality within the studied context.

Table 13: Summary of Mindfulness Dimensions with Statistically Significant Effects on Patient-Perceived Care Quality

| Determinants of Mindfulness | Acting with Awareness | Non-Judgemental | Non-Reactive |
|-----------------------------|-----------------------|-----------------|--------------|
| Our Study Results | Yes | NO | Yes |

Table 13 summarizes the mindfulness dimensions that showed a statistically significant interaction with the patient's perceived quality of care. When combined, the findings suggest that patients' perceived quality of care is significantly determined by mindfulness-related behaviors exhibited in service encounters. Dimensions related to communication clarity and emotional regulation were more salient to service recipients than the internally oriented aspects of mindfulness. In high-demand public healthcare settings, consistent patient perceptions of care quality reflect the reliability of service encounter over time. From an enterprise perspective, physicians' consistency in service delivery represents an important foundation for the sustainability of healthcare enterprises operating under resource constraints and with continuous service pressure.

Discussion: This study discusses mindfulness as a human capital in healthcare companies and its connection with patient satisfaction with quality-of-care ratings in a highly judgmental environment from hospital in India. The results offer empirical evidence on the role of certain aspects of mindfulness in service interactions, which enhances the body of existing literature on the question of workforce sustainability and service delivery in service-based businesses.

Regression findings suggest that mindfulness, as a multidimensional construct, can be used to describe a large percentage of the variation in patient-perceived care quality. This conclusion is consistent with the idea that internal human-based abilities are crucial for maintaining service performance in

healthcare ventures, where service value is significantly co-created during interpersonal interactions. In the service entrepreneurship approach, the presented results contribute to the argument that the sustainability of service enterprises is not merely a matter of structural or technological aspects but also the cognitive and emotional abilities of service professionals.

Food is assessed in the context of sustainable service entrepreneurship. The study shows that mindfulness is a human capital potential that determines how healthcare firms would create value through interactions. Competitive advantage and long-term sustainability in service-oriented organizations such as hospitals are not in terms of physical qualities but of the quality and consistency of encountering human beings. Mindfulness-based skills, particularly communication and emotional regulation skills, assist physicians in coping with relational demands more effectively, enabling service continuity and organizational sustainability in high-contact service settings.

Of the dimensions of mindfulness discussed, the description of the experiences was identified as a strong positive predictor of the quality of care from the perspective of patients. This implies that doctors who are better positioned to explain clinical information with less effort, convey diagnoses, and pass information regarding treatment are more likely to be considered as providing quality care. Good communication is one of the core elements of the processes involved in service value creation in the healthcare business, and the findings acquired are similar to those that have been reported in the literature over the years, which have highlighted the

importance of being articulate and explanatory in enhancing service relationships and patient confidence.

The awareness dimension of acting was also statistically significant in its relationship with the quality of care in the patient's perception. Although the regression coefficient was not positive, this should be viewed with caution and in the context of service environments that are under high pressure. In situations related to government healthcare businesses, where workloads and time pressure are high, gaining more awareness in terms of tasks can be a marker of efficiency-oriented behavior that does not centre on long-term interpersonal engagement but on clinical accuracy. This means that there is a potential battle between the effectiveness of operations and the quality of relationship services and the need to ensure a balanced mindfulness practice that would supplement attentional focus and the need to embrace patients.

These findings also indicate that healthcare businesses do not compete solely on clinical factors but also on the quality of relational services. The key service evaluation dimensions when patients have limited choices are trust, perceived attentiveness, quality of interaction, and limited choice in the healthcare system. Enterprise legitimacy and sustainability in the long term through relational value creation based on mindfulness-related behaviors that result in increased clarity, responsiveness, and emotional stability would thus be supported by the service ecosystem.

Similarly, non-reactivity was found to have a statistically significant relationship with the patient's perceived care quality. Non-reactivity is the capacity to control emotional reactions in stressful interactions, which is especially applicable in high-contact service environments such as healthcare. The reported correlation implies that emotional regulation can affect patients' perceptions during encounters with services, particularly in settings where a physician has to handle several conflicting patient needs. Nevertheless, excessive emotional aloofness can also be construed by service recipients as diminished interpersonal interaction, which is why the development of non-reactivity, in addition to empathy and responsiveness, is essential.

In contrast, observation and non-judgment did not result in statistically significant changes in the quality of care perceived by patients. These results indicate that internal awareness and non-evaluative attitudes could be helpful in maintaining physician well-being, but they are not necessarily measurable and perceivable by patients in short-term service encounters. Resource-constrained public health systems may also experience an increased focus on concrete interactional behavior, such as communication articulation and responsiveness by patients at the cost of their inner state of mind. This distinction indicates the difference between interior

mindfulness experiences and exterior observed service actions.

The lack of a meaningful connection between physician experience and mindfulness also implies that the capabilities associated with mindfulness are not necessarily developed in the course of clinical practice. This observation conforms to the perception that mindfulness can be acquired and is not a result of professional experience. In terms of human capital development, this strengthens the need for systematic intervention and continuous capability-building processes among healthcare enterprises, as opposed to basing them on experience.

Collectively, the results add to the body of knowledge on sustainable service entrepreneurship, proving that particular dimensions of mindfulness serve as human capital abilities that predetermine service interactions in healthcare firms. The findings suggest that communication-focused, awareness-focused, and emotion regulation mindfulness practices could help provide sustainability of service by positively influencing patients' perceptions of the quality of care. Nevertheless, the results also indicate that mindfulness interventions must be tailored to the demands of efficiency and quality of relational services, especially in large public healthcare populations. By incorporating mindfulness into the human capital capacity paradigm, the proposed study can contribute to the existing body of knowledge in the field of entrepreneurship and sustainability by linking individual-level cognitive and emotional assets to service delivery at the enterprise level.

This study demonstrates the possible importance of mindfulness-based capability development in workforce development strategies for healthcare enterprises. Instead of seeing mindfulness as an individual well-being intervention, healthcare organizations can find it beneficial to see it as a strategic human capital investment that facilitates sustainable service provision. This practice is in line with the goals of entrepreneurship and sustainability in young economies, where service businesses face the challenge of simultaneously addressing resource-related limitations, staff-level welfare, and service quality demands at the same time.

Scope and Limitations: This research was conducted at a leading government hospital in Hyderabad, an urban setting. Similar research in government hospitals located in urban, extra-urban, towns, and rural areas, or a combination with specialists in acute, chronic, or niche therapies, would significantly contribute to the field of mindfulness.

Conclusion: This study focused on the capability of mindfulness as part of human capital in healthcare companies and its correlation with patient-perceived quality of care in a busy government hospital in India.

By applying mindfulness to the model of sustainable service entrepreneurship, this study expands the current research on mindfulness beyond the individual well-being approaches to show that it is applicable to the service quality of interaction and the sustainability of enterprises in resource-limited settings.

The results suggest that mindfulness, as a multidimensional ability, can be used to explain a significant part of patient-perceived care quality. In particular, the capability of physicians to articulate clinical data and control their emotional reactions proved to be important factors that predetermined the assessment of service encounters among patients. The findings highlight that service value in the case of a healthcare business is extensively co-created during the process of interpersonal interaction, with the clarity of communication and emotional stability factors playing a key role compared to clinical competence.

Simultaneously, the existence of counter-correlations in some dimensions of mindfulness emphasizes that mindfulness does not exist in all service situations. Under conditions of task pressure, time constraints, and high volumes of work in the context of public healthcare, an increased level of task-related consciousness can sometimes act as an obstacle to the relational quality of service encounters. This highlights the need to consider the concept of mindfulness as a situational ability whose influence on service performance is conditional on its implementation in specific organizational and service situations. The lack of any meaningful correlation between physician experience and mindfulness further indicates that capability building is not invariably acquired over time in the course of professional experience, which supports the necessity of consciously and systematically developing capabilities.

Based on service entrepreneurship and sustainability, the study shows that service quality, as perceived by patients, can be used as an effective indicator of sustainable service performance in healthcare businesses. Research on mindfulness-based capability development as an investment potential might thus result in workforce well-being, as well as in relational service quality, trust, and service continuity. In general, the research frames mindfulness as a strategic human capital asset of healthcare organizations in new economies, and the message associated with further implications for workforce development, service design, and sustainability-driven management behavior. Further studies can build on this research and incorporate financial, functional, or innovation-related performance to continue defining mindfulness as an enterprise-level competency.

Acknowledgment: We extend our sincere gratitude to the gynecologists at Government Hospital,

Hyderabad, for their invaluable support and active participation in this research.

Funding of the Study: None

Conflict of Interest: None

Declaration of AI Assistance Process: The authors indicate that the artificial intelligence tool, PAPERPAL, was employed exclusively for language editing, grammatical correction, and enhancing the clarity of expression. AI tools were not used for study design, data analysis, data interpretation, creation of original scientific content, or formulation of conclusions.

Author Contributions: We sincerely thank Mr. Ganesh (MBA, Batch of 2025) for administering the questionnaire and Ms. Haritha K (MBA, Batch of 2026) for arranging the data for data analysis and Interpretation.

Ethical Committee approval: We explained the study to both gynecologists and patients. After obtaining, their positive consent, questionnaire was administered for capturing their responses

Data availability: All supporting data will be made available upon request.

Abbreviation's:

- FFMQ: Five Facet Mindfulness Questionnaire.
- PPLC: Patient's Perception of Physician-Centered Sub service scale

References:

1. Martins A, Branco M. C., Melo P. N., & Machado, C. (2022). Sustainability in SMEs: A systematic review. *Sustainability*, 14(11), 6493. <https://doi.org/10.3390/su14116493>
2. Dote-Pardo, J., Ortiz-Cea, V., Peña-Acuña, V., Severino-González, P., Contreras-Henríquez, J. M., & Ramírez-Molina, R. I. (2025). Innovative entrepreneurship and sustainability in emerging countries. *Sustainability*, 17(2), 658. <https://doi.org/10.3390/su17020658>
3. Kosasih, W., Pujawan, I. N., & Karningsih, P. D. (2023). Lean-green practices and SME sustainability. *Sustainability*, 15(16), 12192. <https://doi.org/10.3390/su151612192>
4. Liu, Z., Shi, Y., & Yang, B. (2022). Open innovation in healthcare during a crisis. *Journal of Open Innovation: Technology, Market, and Complexity*, 8(1), 21. <https://doi.org/10.3390/joitmc8010021>
5. Khan, M. J., Ahmad, S., Halim, H. A., & Ahmad, N. H. (2022). Service innovation orientation and innovation performance in Indian hospitals. *SAGE Open*, 12. <https://doi.org/10.1177/21582440221116110>

6. Annamalah, S., Aravindan, K. L., & Ahmed, S. (2025). Driving open innovation in SMEs. *Journal of Innovation and Entrepreneurship*, 14, 119. <https://doi.org/10.1186/s13731-025-00588-4>
7. Good D. J., Lyddy C. J., Glomb, T. M., Bono, J. E., Brown, K. W., Duffy, M. K., Baer, R. A., Brewer, J. A., & Lazar, S. W. (2015). Contemplating mindfulness at work. *Journal of Management*. <https://doi.org/10.1177/0149206315617003>
8. Thiermann, U. B., & Sheate, W. R. (2021). Mindfulness and sustainability: A research agenda. *Journal of Cognitive Enhancement*, 5, 118–139. <https://doi.org/10.1007/s41465-020-00180-6>
9. Zalis, L., Prochazka, J., & Vaculik, M. (2019). Managerial trait mindfulness and subordinate job performance. *Frontiers in Psychology*, 10, 2171. <https://doi.org/10.3389/fpsyg.2019.02171>
10. Liu, S., Xin, H., Shen, L., He, J., & Liu, J. (2020). Individual and team mindfulness and work engagement. *Frontiers in Psychology*, 10, 2928. <https://doi.org/10.3389/fpsyg.2019.02928>
11. Bartlett, L., Buscot, M.-J., Bindoff, A., Chambers, R., & Hassed, C. (2021). Mindfulness, stress, and work engagement. *Frontiers in Psychology*, 12, 724126. <https://doi.org/10.3389/fpsyg.2021.724126>
12. Chinchilla, A., & Garcia, M. (2017). Social entrepreneurship intentions and mindfulness. *Humanistic Management Journal*, 1, 205–214. <https://doi.org/10.1007/s41463-016-0013-3>
13. Bui, A., & Pham, M. (2022). Mindfulness and social entrepreneurial intention. *Entrepreneurial Business and Economics Review*, 10(1), 145–160. <https://doi.org/10.15678/EBER.2022.100110>
14. Maslach, C., and Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World psychiatry*, 15(2), 103–111.
15. Shanafelt T. D., West C. P., Sinsky, C., et al. (2012). Changes in burnout and satisfaction with work-life balance among physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90(12), 1600–1613.
16. West, C. P., Dyrbye, L. N., and Shanafelt, T. D. (2016). Physician burnout: Contributors, consequences, and solutions. *Journal of Internal Medicine*, 283(6), 516–528.
17. Dyrbye, L. N., Shanafelt, T. D., and West, C. P. (2017). Addressing physician burnout: The way forward. *JAMA*, 318(11), 1013–1014.
18. Dewa, C. S., Loong, D., Bonato, S., and Trojanowski, L. (2017). The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open*, 7(6), e015141. <https://doi.org/10.1136/bmjopen-2016-015141>
19. Schrijver, I. (2016). Pathology in the medical profession: Taking the pulse of physician wellness and burnout. *Archives of pathology and laboratory medicine*, 140(9), 976–982.
20. Krasner M. S., Epstein R. M., Beckman, H., Suchman, A. L., Chapman, B., Mooney, C. J. and Quill, T. E. (2009). Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *Jama*, 302(12), 1284–1293.
21. Lamothe, M., Rondeau, É., Malboeuf-Hurtubise, C., Duval, M., and Sultan, S. (2016). Outcomes of MBSR or MBSR-based interventions in healthcare providers: A systematic review with a focus on empathy and emotional competencies. *Complementary therapies in Medicine*, 24, 19–28.
22. Shapiro, S. L., Carlson, L. E., Astin, J. A., and Freedman, B. (2006). Mechanisms of mindfulness. *Journal of clinical psychology*, 62(3), 373–386.
23. Regehr C., Glancy D., Pitts A, LeBlanc V. R. (2014). Interventions to reduce the consequences of stress in physicians: A review and meta-analysis. *The Journal of nervous and mental disease*, 202(5), 353–359.
24. Escuriex, B. F., and Labbé, E. E. (2011). Health care providers' mindfulness and treatment outcomes: A critical review of the research literature. *Mindfulness*, 2, 242–253.
25. Epstein M. Street R. L. (2011). The values and value of patient-centered care. *Annals of Family Medicine*, 9(2), 100–103.
26. Beach, M. C., Saha, S., and Cooper, L. A. (2013). The role and impact of the physician-patient relationship on health outcomes: A systematic review. *The Journal of General Internal Medicine*, 28(5), 553–558.