Drivers of Medical Workforce Performance: The Mediating Role of Spiritual Motivation in Islamic Hospitals

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Abstract

Medical workforce performance is central to the quality, safety, and continuity of hospital services. In Islamic hospitals, performance may be shaped not only by clinical capability and professional standards but also by ethical commitments and spiritually meaningful work. This study examines the relationships of professional competence, professional ethics, work–life balance, and burnout with medical workforce performance, while considering spiritual motivation as an intervening construct. An exploratory mixed-methods design was used. The quantitative component involved a census of 206 medical personnel working in Islamic hospitals in Bekasi Regency, Indonesia, and the structural relationships were assessed using partial least squares structural equation modelling (PLS-SEM). The qualitative component comprised 20 in-depth interviews; the dissertation reports 198 initial codes, 38 subthemes, and 13 overarching themes. Professional competence ($\beta = 0.544$, $p < .001$), professional ethics ($\beta = 0.138$, $p = .003$), work–life balance ($\beta = 0.082$, $p = .001$), and spiritual motivation ($\beta = 0.251$, $p < .001$) had positive and statistically significant direct associations with performance. Burnout was positive but not significant ($\beta = 0.008$, $p = .687$). Professional ethics and professional competence were positively associated with spiritual motivation, whereas work–life balance and burnout were not statistically significant predictors of spiritual motivation. The reported indirect effects through spiritual motivation were significant for professional competence ($\beta = 0.237$, $p < .001$) and professional ethics ($\beta = 0.249$, $p < .001$), but not for work–life balance or burnout. The model explained 96.1% of the variance in performance and 89.7% in spiritual motivation. Interview themes emphasized clinical capability, patient safety, confidentiality, sincerity, family support, shift scheduling, and emotional exhaustion. The findings suggest that hospital workforce strategies should integrate continuous professional development, ethical governance, spiritually congruent organizational practices, and practical measures to protect staff well-being.

Keywords: Medical workforce performance; Professional competence; Professional ethics; Spiritual motivation; Work–life balance

INTRODUCTION

Hospitals depend on a capable and sustainable workforce to provide safe, timely, effective, and patient-centred care. Medical personnel must combine technical knowledge with clinical judgement, communication, ethical conduct, and the ability to respond to emotionally demanding situations. These requirements are especially salient in hospitals operating within an explicit religious identity, where patients and employees may expect professional care to be consistent with institutional values and Islamic principles of trustworthiness, justice, compassion, and service.

The dissertation underlying this article identifies several operational concerns in Islamic hospitals in Bekasi Regency. Internal reports cited in the source describe average human-resource productivity declining by approximately 12% over two years, patient satisfaction at 68% in 2024, annual employee turnover of approximately 15–20%, and hospital profit achievement at around 75–80% of target over the preceding three years. These figures are reported as contextual information from

hospital and local sources in the dissertation; they are not independently audited in this article and should be checked against the original institutional records before publication.

The local context points to a managerial challenge. Hospitals need to maintain clinical quality and patient trust while managing resource constraints, service targets, shift work, and staff well-being. Medical professionals may experience competing demands: they are expected to meet institutional performance indicators while protecting patient interests and maintaining professional independence. If organizational targets are not balanced with ethical safeguards, the risk of role conflict and reduced trust may increase.

Human capital theory views employees' knowledge and capabilities as productive assets developed through education, experience, and investment (Becker, 1964). In healthcare, however, technical capability alone is insufficient. Competence must be exercised within ethical relationships and supported by work systems that allow staff to perform reliably. This study therefore examines professional competence, professional ethics, work–life balance, and burnout together, while including spiritual motivation as a potentially meaningful resource in an Islamic hospital environment.

The dissertation argues that medical workforce performance in Islamic hospitals is influenced by a combination of professional, psychological, organizational, and spiritual factors. Professional competence is expected to support accurate clinical decisions, effective communication, and adherence to procedures. Professional ethics provides standards for confidentiality, honesty, fairness, patient autonomy, and accountability. Work–life balance may help employees maintain sufficient recovery time and attention across work and non-work roles. Burnout, by contrast, reflects prolonged occupational strain and may undermine emotional energy and patient engagement.

Spiritual motivation is relevant because work in an Islamic hospital may be understood by employees as both a professional responsibility and a form of service or worship. Fry's (2003) theory of spiritual leadership links vision, altruistic love, and meaningful work with motivation and organizational outcomes. Reave (2005) similarly reviewed evidence connecting spiritual values such as integrity, honesty, and humility with leadership effectiveness. These perspectives provide a rationale for examining spirituality as an organizationally meaningful construct, without assuming that religious commitment can substitute for adequate staffing, safe workloads, or clinical governance.

The study is also motivated by inconsistent expectations about burnout. The Job Demands–Resources model proposes that sustained job demands can deplete energy, whereas job resources can support motivation and engagement (Bakker & Demerouti, 2007). Yet professional obligations, team support, and personal meaning may influence how employees sustain performance under strain. A non-significant burnout coefficient in one cross-sectional sample should therefore not be interpreted as evidence that burnout is harmless. Recent evidence links nurse burnout with poorer patient safety, patient satisfaction, and quality of care (Li et al., 2024).

The study has four objectives. First, it estimates the direct associations of professional competence, professional ethics, work–life balance, and burnout with medical workforce performance. Second, it examines the associations of these four factors with spiritual motivation.

Third, it assesses the indirect relationships between the four factors and performance through spiritual motivation. Fourth, it integrates interview findings with the quantitative results to explain how medical personnel understand professional performance in an Islamic hospital context.

The empirical contribution is a joint examination of professional capability, ethical conduct, work–life balance, burnout, and spiritual motivation in a single hospital-workforce model. The contextual contribution is the focus on Islamic hospitals in Bekasi Regency, where spiritual language and values are part of the institutional setting. The practical contribution concerns the design of human-resource practices that connect clinical development and ethical accountability with staff support and meaningful work.

The article does not claim that this is the first study of spirituality or professional performance in healthcare, nor that the model is universally generalizable. Its contribution is more appropriately framed as context-specific evidence from a defined Indonesian hospital setting. The study's high R^2 values indicate substantial in-sample explanatory power, but they do not by themselves establish predictive validity or prove that the model will perform equally well in other hospitals.

The remainder of the article is organized as follows. Section 2 develops the conceptual arguments and hypotheses. Section 3 describes the mixed-methods design, population, measures, and analyses. Section 4 reports the measurement and structural results alongside the qualitative themes. Section 5 discusses the findings and their implications. Section 6 concludes with limitations and directions for further research.

LITERATURE REVIEW AND HYPOTHESES

Medical Workforce Performance

Medical workforce performance refers to the extent to which healthcare personnel carry out assigned responsibilities effectively and in accordance with professional and organizational standards. In the source study, performance is represented through service quality, work productivity, patient satisfaction, and timeliness. These dimensions capture both task execution and the experience of care, although the available data do not establish that patient satisfaction was independently measured from staff self-reports.

Performance in healthcare is multi-dimensional. It depends on individual knowledge and skills, team coordination, the availability of equipment and information, leadership, and the design of work processes. Consequently, performance management should avoid treating employee output as an isolated individual attribute. A strong employee may still be constrained by staffing shortages, inefficient workflows, or inadequate clinical resources.

Professional Competence

Professional competence is the integrated capacity to apply relevant knowledge, clinical skills, communication, analysis, and professional judgement in practice. Boyatzis (1982) conceptualized competence in relation to effective performance, while Becker (1964) emphasized the productive value of knowledge and skills developed through investment in human capital. In this study, competence includes medical knowledge, clinical skills, communication, and analytical ability;

questionnaire items also cover procedural knowledge, teamwork, continuous learning, technology use, and emergency response.

Competent medical personnel are more likely to make timely decisions, follow standard operating procedures, communicate effectively with patients, and coordinate care. These capabilities should translate into stronger performance. The study therefore proposes: H1: Professional competence is positively associated with medical workforce performance.

Professional Ethics and Spiritual Motivation

Professional ethics provides normative guidance for decisions and interactions in clinical practice. Beauchamp and Childress (2017) identify respect for autonomy, beneficence, non-maleficence, and justice as central principles of biomedical ethics. In the present setting, the dissertation additionally emphasizes confidentiality, honesty, fairness, informed consent, responsibility, and the protection of patient interests. Ethical conduct can strengthen trust and reduce the risk that organizational targets displace patient-centred judgement.

In Islamic ethical thought, concepts such as amanah (trust), adl (justice), and ihsan (excellence) can reinforce professional responsibility. Such values should be translated into observable practices—accurate communication, confidentiality, respectful treatment, and accountability—rather than treated only as abstract declarations. Ethical conduct may also reinforce spiritual motivation by aligning daily professional responsibilities with employees' values and sense of purpose.

Spiritual motivation is conceptualized as an intrinsic drive informed by meaning, religious awareness, altruistic service, and a sense of calling. Fry (2003) argues that meaningful work and altruistic values can support motivation and commitment. In the dissertation, indicators include meaningful vision, altruism, calling, spiritual belief, and religious awareness. The expected relationship is not that spirituality guarantees clinical competence, but that it may strengthen employees' willingness to approach their work with sincerity and responsibility.

H2: Professional ethics is positively associated with medical workforce performance. H3: Professional ethics is positively associated with spiritual motivation. H4: Spiritual motivation is positively associated with medical workforce performance.

Work–Life Balance, Burnout, and The Mediating Framework

Work–life balance concerns the perceived ability to manage work and personal responsibilities without persistent conflict. Boundary and role-transition perspectives emphasize that people move between work and non-work domains and that the boundaries between these roles influence well-being (Ashforth et al., 2000; Clark, 2000). Work–family enrichment theory further suggests that resources and positive experiences in one domain may benefit the other (Greenhaus & Powell, 2006). For shift-based medical personnel, predictable schedules, recovery time, family support, and access to leave may be important.

H5: Work–life balance is positively associated with medical workforce performance. H6: Work–life balance is positively associated with spiritual motivation.

Burnout is commonly described through emotional exhaustion, depersonalization or cynicism, and reduced professional efficacy. Maslach and Jackson (1981) developed a widely used measure of

experienced burnout. The dissertation operationalizes burnout through emotional exhaustion, depersonalization toward patients, loss of motivation, and feelings of pressure. Under the Job Demands–Resources model, excessive demands and inadequate resources may contribute to strain (Bakker & Demerouti, 2007).

H7: Burnout is associated with medical workforce performance. H8: Burnout is associated with spiritual motivation. Given the possibility that personal meaning and organizational resources may shape the experience of strain, the direction and magnitude of these relationships require empirical testing.

The mediation framework proposes that spiritual motivation may transmit some of the associations between competence, ethics, work–life balance, and burnout and performance. H9–H12: Professional competence, professional ethics, work–life balance, and burnout have indirect associations with performance through spiritual motivation, respectively. The hypotheses are assessed using the indirect-effect estimates reported in the source study.

RESEARCH METHOD

Research Design and Setting

The study used an exploratory mixed-methods design combining a structured survey with qualitative interviews and observations. The quantitative component was intended to estimate relationships among the study constructs, while the qualitative component was used to contextualize the statistical patterns and capture staff experiences. The research was conducted among medical personnel working in Islamic hospitals in Bekasi Regency, West Java, Indonesia. The source dissertation identifies doctors, specialist doctors, nurses, midwives, and other personnel directly involved in healthcare services as the target population.

The dissertation reports a population of 206 active medical personnel and states that all 206 were included through a census approach. The methods section also contains references to purposive and stratified sampling, creating an inconsistency in the sampling description. For this article, the reported total of 206 and the explicit statement that all members of the population were included are treated as the operative quantitative design. The author should verify the sampling procedure and provide the number of participating hospitals and response rate before submission.

Quantitative Data Collection

Survey data were collected using a structured questionnaire with five-point Likert response options, ranging from 1 (strongly disagree) to 5 (strongly agree). The questionnaire covered spiritual motivation, work–life balance, burnout, professional ethics, professional competence, and medical workforce performance. The dissertation indicates 15 items for each of the six constructs. The measurement indicators were informed by the theoretical sources cited in the dissertation and were adapted to the hospital setting.

The available source does not provide a complete item-by-item instrument validation history, the dates of survey administration, missing-data treatment, or the demographic profile of the 206 respondents. These details should be supplied by the author to support transparent replication.

Qualitative Data and Analysis

The qualitative component comprised 20 in-depth interviews with medical personnel. The dissertation describes the interviews as semi-structured and indicates that they were used to explore experiences and perceptions related to the study variables. The source reports that 198 initial codes were generated during open coding, consolidated into 38 subthemes through axial coding, and organized into 13 overarching themes through selective coding. NVivo was used to support coding and cross-case analysis. The researcher also reports the use of analytic memos, an audit trail of coding decisions, peer debriefing, and consistency checks across interview excerpts.

The qualitative analysis followed an iterative process of data reduction, display, and conclusion development, consistent with the approach attributed in the dissertation to Miles and Huberman. The reported interview material includes brief illustrative quotations identified by respondent codes. In this article, quotations are retained only where they are explicitly presented in the dissertation; no new participant quotations have been created.

Quantitative Analysis

The quantitative model was analyzed using partial least squares structural equation modelling (PLS-SEM). The dissertation reports an assessment of the measurement model through indicator loadings, average variance extracted (AVE), composite reliability, and discriminant validity. The structural model was assessed using path coefficients, bootstrapped t-statistics and p-values, and coefficients of determination (R^2). PLS-SEM reporting should distinguish measurement quality, explanatory power, and out-of-sample prediction; a high R^2 alone does not establish predictive performance (Hair et al., 2019).

The dissertation applies a two-tailed 5% significance threshold, using $t > 1.96$ and $p < .05$ as the decision criteria. The source reports Q^2 values for performance and professional competence, although the model's endogeneous-construct labeling is not fully consistent across sections. The article reports these values descriptively and recommends verification of the blindfolding output.

RESULTS AND DISCUSSION

Measurement Model

The reported indicator loadings ranged from approximately 0.683 to 0.912 across the constructs. Most indicators met or exceeded the commonly used 0.70 reference value, although two work–life balance indicators were slightly below that threshold (0.683 and 0.689). These values should be interpreted alongside content validity and construct-level reliability rather than used as an automatic basis for deleting indicators.

All six constructs exceeded the reported AVE threshold of 0.50. Composite reliability values ranged from 0.893 to 0.961, indicating high internal consistency in the reported model. The Fornell–Larcker matrix presented in the dissertation shows that the square roots of AVE on the diagonal exceed the corresponding inter-construct correlations. This supports the reported assessment of discriminant validity, although additional modern checks such as the heterotrait–monotrait ratio (HTMT) are not documented in the source.

Table 1. Measurement Model Summary

Construct	AVE	Composite reliability	Assessment
Burnout	0.553	0.893	Acceptable
Professional ethics	0.581	0.916	Acceptable
Performance	0.564	0.902	Acceptable
Professional competence	0.742	0.961	Acceptable
Spiritual motivation	0.572	0.907	Acceptable
Work–life balance	0.601	0.918	Acceptable

Source: data processed

The dissertation also reports Cronbach's alpha of 0.957 for spiritual motivation. This value is consistent with high internal consistency, although very high reliability coefficients can sometimes indicate item redundancy. The complete construct-level Cronbach's alpha results for the other variables should be added to the final manuscript if available.

Structural Model and Direct Relationships

The structural estimates indicate that professional competence had the largest positive direct association with medical workforce performance ($\beta = 0.544$, $t = 12.538$, $p < .001$). Spiritual motivation was also positively associated with performance ($\beta = 0.251$, $t = 5.726$, $p < .001$). Professional ethics showed a smaller but significant positive association ($\beta = 0.138$, $t = 2.928$, $p = .003$), as did work–life balance ($\beta = 0.082$, $t = 3.198$, $p = .001$). Burnout had a very small positive coefficient that was not statistically significant ($\beta = 0.008$, $t = 0.404$, $p = .687$).

Table 2. Direct Path Estimates

Path	B	t	p	Decision
Professional competence → Performance	0.544	12.538	< .001	Significant
Spiritual motivation → Performance	0.251	5.726	< .001	Significant
Professional ethics → Performance	0.138	2.928	0.003	Significant
Work–life balance → Performance	0.082	3.198	0.001	Significant
Burnout → Performance	0.008	0.404	0.687	Not significant
Professional ethics → Spiritual motivation	0.458	5.133	< .001	Significant
Professional competence → Spiritual motivation	0.436	4.825	< .001	Significant
Work–life balance → Spiritual motivation	0.070	1.712	0.087	Not significant
Burnout → Spiritual motivation	0.049	1.324	0.186	Not significant

Source: data processed

Professional competence and professional ethics were also positively associated with spiritual motivation ($\beta = 0.436$ and $\beta = 0.458$, respectively; both $p < .001$). In contrast, work–life balance ($\beta = 0.070$, $p = .087$) and burnout ($\beta = 0.049$, $p = .186$) were not statistically significant predictors of

spiritual motivation. The estimates suggest that spiritual motivation in this sample was more closely associated with competence and ethical orientation than with work–life balance or burnout.

Indirect Effects and Explanatory Power

The indirect-effect table reports significant positive pathways through spiritual motivation for professional competence ($\beta = 0.237$, $t = 4.542$, $p < .001$) and professional ethics ($\beta = 0.249$, $t = 4.602$, $p < .001$). The indirect effect for work–life balance was not significant ($\beta = 0.038$, $t = 1.756$, $p = .079$), nor was the indirect effect for burnout ($\beta = 0.026$, $t = 1.323$, $p = .186$). These estimates are consistent with the pattern that professional competence and ethics are related to spiritual motivation, which in turn is related to performance.

Table 3. Specific Indirect Effects through Spiritual Motivation

Indirect pathway	B	t	p	Decision
Professional competence → Spiritual motivation → Performance	0.237	4.542	< .001	Significant
Professional ethics → Spiritual motivation → Performance	0.249	4.602	< .001	Significant
Work–life balance → Spiritual motivation → Performance	0.038	1.756	0.079	Not significant
Burnout → Spiritual motivation → Performance	0.026	1.323	0.186	Not significant

Source: data processed

The model explained 96.1% of the variance in performance ($R^2 = 0.961$; adjusted $R^2 = 0.960$) and 89.7% of the variance in spiritual motivation ($R^2 = 0.897$; adjusted $R^2 = 0.895$). The dissertation reports a goodness-of-fit value of 0.76 and Q^2 values of 0.79 for performance and 0.72 for professional competence. These latter statistics should be checked against the original software output and the correct endogenous constructs before publication. In particular, current PLS-SEM practice recommends supplementing traditional fit and R^2 reporting with prediction-oriented assessment and robustness checks (Hair et al., 2019).

A reporting inconsistency requires attention: parts of the dissertation describe professional competence as a mediator, whereas the abstract and the indirect-effect table identify spiritual motivation as the mediator. The estimates in Tables 2 and 3 of this article follow the explicit reported paths in the coefficient tables. The author should verify the final structural diagram and model specification against the original SmartPLS output.

Qualitative Findings

The qualitative analysis provides context for the statistical pattern. The dissertation reports 20 interview transcripts, 198 initial codes, 38 subthemes, and 13 overarching themes. The summary table groups the most prominent themes around spiritual motivation, professional ethics, work–life balance, burnout, professional competence, and medical workforce performance. The reported frequency labels are indicative outputs from NVivo query matrices rather than population estimates.

Table 4. Selected Qualitative Themes

Main theme	Key subthemes	Illustrative evidence in source
Spiritual motivation	Intention to serve, sincerity, prayer before clinical action	"We work while hoping for God's pleasure, so we must be trustworthy." (R-03)
Professional ethics	Patient confidentiality, informed consent, service etiquette	Confidentiality is treated as a professional boundary (R-12)
Work–life balance	Family support, shift scheduling, recovery time	Stable schedules were linked by informants to greater focus (R-07)
Burnout	Emotional exhaustion, depersonalization, overload	Busy emergency shifts were described as mentally exhausting (R-15)
Professional competence	Clinical skills, evidence-based practice, clinical communication	Updating clinical guidelines was described as essential (R-09)
Performance	Service quality, patient safety, satisfaction	Patient safety and clear communication with families were emphasized (R-02)

Source: data processed

The qualitative accounts suggest that employees interpret performance as more than task completion. They connect good performance with clinical reliability, safe care, respectful communication, and responsibility toward patients. Spiritual motivation is described through sincerity, prayer, and the understanding of work as an entrusted duty. Ethical practice is reflected in confidentiality and respect for patient rights. Work–life balance is discussed in relation to scheduling and family support, while burnout is associated with emotional fatigue and workload pressure.

These themes complement the significant quantitative associations for competence, ethics, work–life balance, and spiritual motivation. They also caution against interpreting the non-significant burnout coefficient as evidence that staff exhaustion is unimportant.

Professional Competence as The Strongest Performance Correlate

Professional competence had the largest direct coefficient in the model. This result is consistent with human capital theory, which treats knowledge and skills as productive resources (Becker, 1964), and with competence-based approaches that link capability to effective performance (Boyatzis, 1982). In a clinical environment, the practical relevance is clear: knowledge, procedural skill, sound judgement, communication, and the ability to respond to emergencies are directly connected to the delivery of reliable care.

The interview themes reinforce this interpretation. Informants emphasized clinical skill, evidence-based practice, and the importance of keeping clinical guidelines up to date. They also described communication as part of professional competence, indicating that technical expertise and interpersonal capability should be developed together. Hospitals should therefore treat continuous professional development as a core operational investment rather than an occasional training activity.

The competence coefficient should nevertheless be interpreted in context. The outcome is a staff performance construct measured in the same survey setting, and common-method variance may inflate associations between self-reported competence and performance. Future studies should triangulate self-assessments with supervisor ratings, clinical audit indicators, patient experience measures, and safety outcomes. This would help establish whether perceived competence translates into independently observed performance.

The significant association between competence and spiritual motivation ($\beta = 0.436$) is also notable. It may reflect that employees who feel capable of fulfilling their professional responsibilities experience greater meaning and confidence in their service. The direction of this relationship cannot be established conclusively in a cross-sectional design, however; spiritual motivation may also encourage learning and skill development.

Professional Ethics and Spiritual Motivation

Professional ethics had a positive direct association with performance and a strong positive association with spiritual motivation. The results suggest that ethical standards are not merely compliance requirements but may be embedded in the way employees understand the purpose of their work. In the Islamic hospital context, values such as amanah, justice, sincerity, and ihsan can provide a culturally meaningful vocabulary for professional responsibility. These values should complement, not replace, established biomedical principles such as autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2017).

The qualitative evidence emphasizes confidentiality, informed consent, honesty, and respectful conduct. Such practices are important because patient trust depends on more than clinical outcomes; it also depends on whether patients are treated fairly and their information is protected. Reave's (2005) review similarly connects spiritual values—including integrity and honesty—with effective leadership practices. The present findings extend this discussion to workforce performance in an Islamic hospital setting, although the study does not test leadership as a separate construct.

The significant indirect association of ethics with performance through spiritual motivation ($\beta = 0.249$) is consistent with a mechanism in which ethical orientation strengthens employees' sense of meaningful service, which is then associated with better performance. Because the direct effect of ethics also remains significant, the pattern is compatible with partial mediation, subject to verification using the original model output and a formal mediation classification. The result should not be described as full mediation.

For management, ethical culture requires operational reinforcement. Hospitals can integrate ethical case discussions, confidentiality audits, informed-consent reviews, transparent complaint mechanisms, and role modelling by senior clinicians. Spiritual language is most credible when it is reflected in fair policies and consistent protection of patient rights.

Work–Life Balance and Burnout: Interpreting The Divergent Results

Work–life balance had a statistically significant but comparatively small positive direct association with performance ($\beta = 0.082$). Its association with spiritual motivation and its indirect effect through spiritual motivation were not significant. This pattern suggests that work–life balance may support performance through practical mechanisms—such as adequate rest, attention, and the

ability to manage competing responsibilities—rather than by directly strengthening spiritual motivation. The qualitative references to shift scheduling, family support, and recovery time are consistent with this interpretation.

The finding is aligned with work–family boundary and enrichment perspectives, which emphasize the interaction between work and personal roles (Ashforth et al., 2000; Clark, 2000; Greenhaus & Powell, 2006). For medical personnel, a manageable schedule may preserve concentration and reduce fatigue. However, the small coefficient indicates that work–life balance is only one part of a broader performance system; it cannot compensate for insufficient staffing, inadequate equipment, or weak clinical processes.

Burnout was not significantly associated with performance or spiritual motivation in the reported model. This result differs from broader evidence linking burnout to adverse healthcare quality and safety outcomes. A recent meta-analysis of 85 studies involving 288,581 nurses found associations between burnout and poorer patient safety, patient satisfaction, and quality of care (Li et al., 2024). A 2024 scoping review also highlights the role of workplace demands and resources in healthcare worker burnout (Nagle et al., 2024).

Several explanations are possible: restricted variation in burnout within the sample, measurement limitations, professional duty, team support, or unmeasured organizational resources. These are plausible interpretations, not tested explanations. The positive but near-zero coefficient ($\beta = 0.008$) should not be interpreted as evidence that burnout improves performance. The correct conclusion is that this study did not detect a statistically significant direct association. Hospitals should continue to monitor workload, emotional exhaustion, depersonalization, recovery time, and psychological support.

CONCLUSION

This study examined the relationships of professional competence, professional ethics, work–life balance, and burnout with medical workforce performance in Islamic hospitals in Bekasi Regency, Indonesia, while considering spiritual motivation as an intervening construct. The quantitative results show that professional competence, professional ethics, work–life balance, and spiritual motivation have positive and statistically significant direct associations with performance. Professional competence is the strongest correlate. Burnout has a positive but statistically non-significant coefficient and should not be interpreted as beneficial or inconsequential.

Professional competence and professional ethics are positively associated with spiritual motivation, and their reported indirect effects through spiritual motivation are significant. The indirect effects for work–life balance and burnout are not significant. Qualitative themes emphasize clinical capability, patient safety, confidentiality, sincerity, family support, shift scheduling, and emotional exhaustion. Taken together, the findings suggest that effective workforce management in Islamic hospitals should integrate competence development, ethical governance, supportive work design, burnout prevention, and meaningful spiritual practices.

The reported R^2 values are high (0.961 for performance and 0.897 for spiritual motivation), but should be interpreted as in-sample explanatory statistics rather than proof of external predictive validity. The model and manuscript require further verification, particularly the inconsistency in the

dissertation's description of the mediator, the sampling terminology, and the reported predictive statistics. Replication across multiple hospitals and the use of objective performance outcomes are needed before broad generalization.

The findings support an integrated view of medical workforce performance in which professional capability, ethical conduct, practical work conditions, and meaningful motivation operate together. The study's context-specific contribution is to show that spiritual motivation can be empirically examined alongside conventional human-resource constructs in Islamic hospitals. It does not establish a universal "Islamic human-resource model," but it provides a basis for further testing of how religiously congruent organizational values interact with professional standards.

First, strengthen continuous professional development through competency mapping, supervised clinical practice, simulation, evidence-based guideline updates, interprofessional communication training, and evaluation of learning transfer. Second, embed ethics in routine governance through confidentiality safeguards, informed-consent protocols, fair treatment, transparent reporting, and accountability mechanisms. Third, improve work design by reviewing shift rotations, ensuring protected breaks, reducing avoidable administrative burdens, and making leave and recovery arrangements workable.

Fourth, treat burnout prevention as a patient-safety and workforce-sustainability priority. Hospitals should assess workload and staffing adequacy, provide confidential psychological support, train managers to recognize early warning signs, and create psychologically safe channels for raising concerns. Spiritual support activities may be offered in ways that are voluntary, inclusive, and responsive to employees' beliefs; they should never be used as substitutes for safe staffing or professional mental-health care.

Fifth, translate spiritual values into observable work practices. Reflection, prayer facilities, spiritual counselling, and values-based leadership may help employees connect their work with a sense of purpose. Their effectiveness should be evaluated through staff feedback and organizational outcomes, while respecting privacy and avoiding coercion.

The study is based on one regency and a cross-sectional design, limiting causal inference and generalizability. The use of self-reported measures may introduce common-method bias. The source does not provide sufficient detail on respondent demographics, hospital count, response rate, ethics approval, missing-data handling, or the complete qualitative sampling strategy. Future studies should use longitudinal or multi-site designs, independent performance indicators, HTMT and predictive assessment, and explicit integration procedures for mixed-methods evidence. The structural-model inconsistency regarding the mediator must also be resolved before publication.

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