Effects of Ethical Leadership Perception on Turnover Intention: The Mediating Role of Organizational Commitment in Oromia Regional State Hospitals

Tesfaye Hirphasa Chala* Bereket Solomon Hadgu†

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Abstract

The study of ethical leadership has an increased relevance due to expansions of business scandals, and unethical behaviors in an organization that compromise of the long-term viability of the firm, and affects the business in a number of ways. Leaders that are guided by ethical leadership principles can bring about significant positive outcomes for their organizations. The purpose of this study is to investigate the relation of ethical leadership perception with turnover intention of health care personnel. Organizational commitment is examined as a mediator of the relationship between ethical leadership and turnover intention. The study is conducted using a sample of 406 employees from 8 public and 3 private hospitals in Oromia region. Different statistical tools are employed to analyze the data collected through questionnaires; including correlation and multiple regressions and it is found that ethical leadership negatively affects turnover intention of health professionals. In addition, organizational commitment is found to be a partial mediator variable for the proposed relations. Based on the findings, it is recommended that ethical leadership practices are enhanced in the hospitals by hiring leaders that are more ethical and providing training to existing leaders on ethical leadership principles. Private hospital owners and managers are also advised to allow their employees to have a say in decision making and should listen to their ideas and concerns because this is the way to win employees' trust and commitment.

Keywords: *Ethical Leadership, Organizational Commitment, Turnover Intention, Mediation*

* Ethiopian Public Service University, Ethiopia. Email: wubetesfa2005@gmail.com

† Ethiopian Public Service University, Ethiopia. Email: solomonbereket10@gmail.com

1. Introduction

Amid today's volatile business environment, questions of ethics and values confront executives, managers, and leaders at multiple levels as they invest their time and energy in driving value creation. Alhaidan (2025) frames ethical leadership more broadly as a capacity that enables leaders to guide and influence others through conduct grounded in honesty, integrity, fairness, and respect; qualities that prove essential for cultivating trust and shaping positive organizational cultures. According to Gallagher and Tschudin (2010), ethical leadership plays a necessary role in surfacing individual, team, and organizational values, and ensuring these are weighed against professional values that uphold dignity and enable the flourishing of individuals, organizations, and society as a whole.

Recent studies emphasize the importance of ethics in organizations, particularly following numerous business scandals. Unethical behavior compromises the long-term viability of a firm and affects the business in multiple ways. First, consumers tend to shy away from products and services of unethical organizations, hurting firm value. Second, some unethical practices are illegal, increasing firms' legal liability and cost. Third, an unethical climate has a pervasive effect on employees through higher workplace stress, lower job satisfaction, and eventually higher turnover; a pattern confirmed in healthcare settings, where ethical work environment and job satisfaction are inversely associated with turnover intention (Romanian chronic care hospital study, 2024; Ethical Climates Meta-Analysis, 2023).

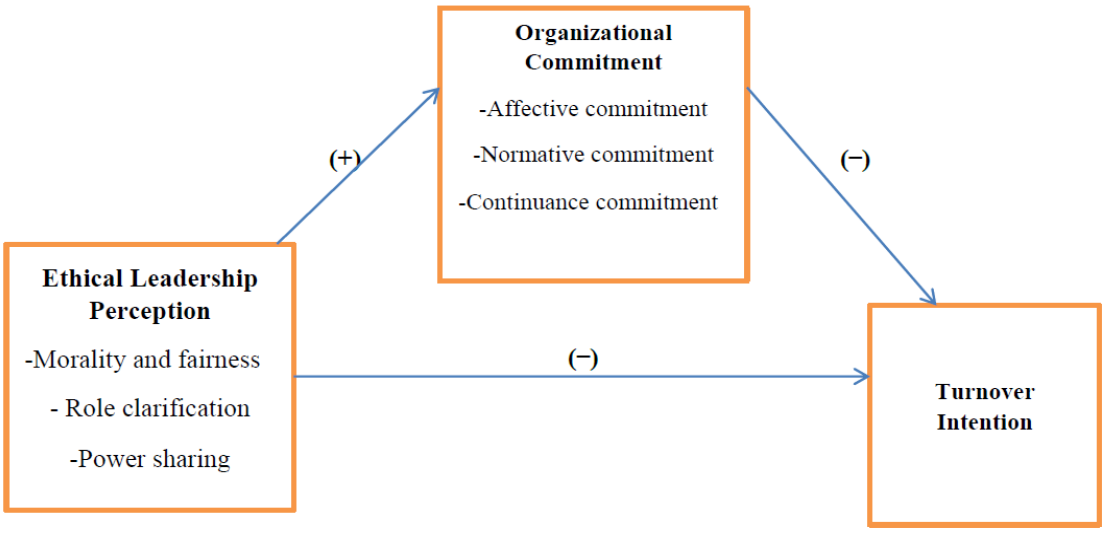
Organizations require ethical leadership and ethical decision-making largely because they remain accountable to a wide range of stakeholder groups. Research indicates that the organizations with the most ethical track records are also the most successful organizations overall (Winston, 2007). Leadership scholarship treats ethical conduct as central to effective leadership. Building on this, Albdareen et al. (2024) argue that when leaders actively embed ethical practices within their organizations, the result is improved employee attitudes and behavioral outcomes; which in turn fuel innovation and operational excellence, underscoring ethical leadership's strategic value for sustained organizational success. Different research studies recognized that good ethics is not only the right thing to do but also it is a good business (IESE Insight, 2011 & Tziner & Persoff, 2024). In the same way, different research findings show that practicing ethical leadership would bring significant positive outcomes for organizations. When employees perceive ethical leadership in an

organization, they respond by increasing their commitment to the organization. More recently, studies affirm that employees' trust in leadership and organizational commitment are direct outcomes of ethical leadership, particularly when leaders demonstrate sincerity, discipline, and strong moral values in decision-making. Employees who perceive highly ethical leadership behavior exhibit higher levels of commitment (Basilio, 2025; Mitonga-Monga and Cilliers, 2016).

Callado et al. (2023) define turnover intention as the deliberate mental state in which an employee considers leaving the organization; essentially the last psychological stage preceding actual resignation. Organizational commitment, by contrast, captures how strongly an individual identifies with the organization and wishes to remain part of it, manifested through belief in its goals, effort exerted on its behalf, and ongoing loyalty. Turnover is costly to organizations across sectors given the substantial investment in recruitment, selection, and training of personnel, and remains a major concern for workforce stability worldwide. Beyond these direct costs, elevated turnover intention also generates indirect losses such as declining morale among remaining staff, increased workload, and erosion of institutional and social capital (Dhoopar et al., 2026).

Studies consistently show that employees' perception of ethical leadership negatively influences their turnover intention, with ethical leaders lowering turnover intention in their work units partly by shaping a stronger ethical climate (Saleh et al., 2022). At the same time, ethical leadership plays an equally important and positive role in building organizational commitment. Leaders who consistently model integrity, fairness, and moral decision-making strengthen employees' trust in leadership and deepen their psychological attachment to the organization, which in turn enhances long-term commitment and organizational success (Basilio, 2025). This dual influence positions ethical leadership as a driver of both outcomes, reducing the desire to leave while simultaneously increasing the desire to stay and contribute.

Figure-1, Theoretical model of the study



Source: Own Literature Review, 2026.

Organizational commitment itself also functions as a critical buffer against turnover intention and frequently mediates the relationship between leadership and employees' intention to leave; for example, organizational commitment has been shown to mediate the effect of workplace and leadership-related factors on nurses' turnover intention in hospital settings (Xia et al., 2023).

Miller (2008) identifies employee turnover as a pressing concern for organizational managers, one that has traditionally been regarded as detrimental to the organization's bottom line. Federal Ministry of Health, Ethiopia, (2024) indicate that brain drain, high turnover of health staff, especially medical doctors, shortage and attrition of highly skilled professionals lack of human resource motivation and retention strategies are among challenges faced by Ethiopian health sector. Health institutions in Ethiopia are characterized by bureaucratic management, poor participation and interaction with team members and supervisors, low morale and motivation of health care workers, poor policies and practices for human resource development, and lack of supportive supervision for health workers, brain drain, high turnover of health staff, especially medical doctors, shortage & attrition of highly skilled professionals, and lack of human resource retention strategies (Elfios et al., 2024). Acknowledging this shortage, the Ethiopian Hospital Management Initiative, operating under the Ethiopian Federal Ministry of Health made improving healthcare worker retention a key priority. Leadership plays a key role in retaining and efficiently utilizing the skill of health professionals in hospitals.

Yet, many low-income countries that have received substantial increases in funding to rapidly expand services continue to struggle with fundamental gaps in health institution administrative capacity. Arage et al., (2022) reports that, historically, far greater emphasis has been placed on clinical knowledge and skills than on the broader competencies such as leadership, accounting, procurement, and logistics required to run health systems effectively and efficiently. The report further notes that health workers respond favorably to a range of nonfinancial incentives, most of which can be grouped under the umbrella of strong leadership, benefits that extend to health workers across every level of the health system. The report listed different factors that improve individual or organizational performance of health institutions. Health sector employees are more committed to perform well when their organization and leader/supervisor at every level; regardless of their role recognize and value employees, actively seek in feedback/input & increase their participation in decision making since they have hands on and practical solution. Leaders are also expected to build teamwork alongside mentoring & coaching; encourage innovation and appropriate independence, foster a culture centered on benchmarking and comparative learning and both provide feedback on strong performance, rewarding it accordingly. Motivating factors in the report for health works are highly correlated with ethical leadership dimensions or characteristics; to mention sanction for poor performance and rewarded for good performance, which is transactional nature of ethical leadership, culture of bench marking that is setting standards and make people recognized and valued, which is people orientation of ethical leadership.

Despite this theoretical and practical significance; the effect of ethical leadership on health sector employees' attitudinal outcome has not been explored in Ethiopian context. Hence, this research is envisioned to investigate the associations between; ethical leadership perception of clinical staffs and their commitment level to the hospitals and ethical leadership perception of clinical staffs and their intention to quit job. The indirect effect of organizational commitment on the relation between ethical leadership perception and turnover intention is also addressed. Based on review of literature, the following hypotheses are proposed and examined to attain the research objectives. These are:

H_1: *There is significant positive relation between ethical leadership perception among clinical staff and their organizational commitment level*.

H_2: *There is significant negative relation between ethical leadership perception among clinical staff and their turnover intention*.

H_3: *The relation between ethical leadership perception of clinical staff and their turnover intention is strongly mediated by organizational commitment*.

2. Material and Method

2.1. Study Design and Sample

Explanatory research design is adopted to undertake the study since it is intended to investigate the relationship between ethical leadership, organizational commitment and turnover intention. Population for the study comprises of all medical doctors and clinical nurses (fulltime workers) in public and private/NGO hospitals of Oromia National Regional State of Ethiopia. Eight public and three private/NGO hospitals are selected for data collection. Based on regional health bureau records, the population totaled 3,178 professionals, comprising 755 medical doctors and 2,423 nurses distributed across 40 public hospitals (District, Zonal, and Referral levels) and 14 private/NGO hospitals. A two-stage systematic sampling approach was used to select facilities. Public hospitals were first stratified by service capacity into District, Zonal, and Referral categories, from which 8 hospitals were systematically selected. Private and NGO hospitals were stratified by inpatient bed capacity, from which 3 hospitals were systematically selected — yielding 11 hospitals in total. Across the 11 selected hospitals, the eligible workforce comprised 856 physicians and professional nurses (178 physicians and 478 nurses in public hospitals; 39 physicians and 161 nurses in private/NGO hospitals).

The eight public hospitals from which data were collected were: Adama (Referral), Ambo (Zonal), Ciro (Zonal), Fiche (Zonal), Bedele (District), Dodola (District), Shambu (District), and Tulu Bolo (District). Facility selection, therefore, followed a probability-based, two-stage systematic procedure, whereas respondents within each selected facility were recruited through a non-probability, availability-based approach; the study thus employed a mixed sampling design combining both techniques at different stages of the sampling process.

To identify the unit of analysis, a nonprobability sampling was utilized at each of the selected hospitals in such way to include all physicians and professional nurses who happened to be available within a specific timeframe (typically a two-day window). A convenience approach to respondent recruitment was considered both practically and ethically appropriate in this context,

since hospital management could not release clinical staff from duty for research purposes given limited staffing per shift and the complexity of rotating shift schedules. Totally 856 physicians and professional nurses were working in the selected public and private hospitals. The questionnaire was administered to all participants available on the data distribution date, together with a covering letter, and participants were asked to return the completed questionnaire within two days. The researchers therefore personally visited each selected hospital over a two-day window to distribute and collect questionnaires directly, in order to maximize the response rate under these constraints. Of 523 questionnaires distributed, 415 were returned, of which 406 were complete and usable, yielding a response rate of 77.6%.

2.2. Research Instruments

The questionnaires employed in this study were adapted from previously validated measurement instruments, i.e. Hanges and Dickson's (2004) Multi-culture Leader Behavior Questionnaires (MCLQ), the three ethical leadership dimensions on which each dimension is measured separately using three different scales. The researcher adopted this three-dimensional 17 items questionnaire to measure ethical leadership behaviors of supervisors. Reponses from participants were evaluated on five-point Likert scale, with scores ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Roodt (2004) Turnover intentions questionnaires, the 14 items were evaluated on a five-point scale with response options ranging from "never" 1, meaning low intensity to "always" 5, indicating high intensity. Meyer & Allen's (1997) Organizational Commitment Questionnaire (OCQ) are used to measure 18 items, 6 sub-items for each dimension. Each of the six items was assessed using a five-point Likert scale, with anchors labeled: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree. Demographic variables (age, years of clinical experience, years in the position and qualifications) are measured on a nominal scale.

2.3. Analysis of Data

After data collection, responses to the questionnaire were organized, coded and entered *via* SPSS (version 26.0) for statistical analysis. For descriptive statistics, means and standard deviations were calculated. To ascertain the extent of relationship between ethical leadership, turnover intention, and organizational commitment Pearson product moment correlations is calculated. To ascertain the relationships between dependent variable, i.e. *turnover intention*, and predictive variables, i.e. *ethical leadership*, regression analysis was conducted. In particular, mediation analysis is used to

determine the extent of effects of *ethical leadership* on turnover intention *via* organizational commitment. A path analysis framework was employed to examine and interpret the findings of the mediation analysis.

Although the instruments selected in this study are all well established, it is necessary to confirm their reliability and validity to adjust its usability to Ethiopian hospital context. The construct validity of the questionnaire is assessed using factor analysis. Factor analysis was conducted for the sake of figuring out aligning items with each dimension of predictive variable, namely ethical leadership and to do the same for each dimension of mediating variable organizational commitment and dependent variable, i.e. turn over intention. To ensure the construct validity of ethical leadership instruments, developed by Den Hartog and De Hoogh (2008), 17 items were analyzed using PCA. Before interpreting the extracted components, suitability of the data for factor analysis was verified. The Kaiser–Meyer–Olkin (KMO) measure of sampling adequacy yielded a value of 0.922, which is well above the recommended threshold of 0.70, indicating that the data were appropriate for factor analysis. Bartlett's Test also confirmed that the correlation matrix was suitable for factor extraction, retained items exhibiting factor loadings of ≥ 0.813 (see Table 1).

Table 1: Rotated Component Matrix

Variable	Factors	Factor loading	Eigen value	% of Variance
Ethical Leadership	Factor 1 (morality & fairness)		7.526	44.273
	Mfd-1	.889		
	Mfd-2	.901		
	Mfd-3	.885		
	Mfd-4	.881		
	Mfd-5	.856		
	Mfd-6	.840		
	Factor 2 (role clarification)		3.449	20.289
	Rcd-1	.903		
	Rcd-2	.901		
	Rcd-3	.874		
	Rcd-4	.903		
	Rcd-5	.901		
	Factor 3 (power sharing)		2.751	16.180
	Psd-1	.813		
	Psd-2	.873		
	Psd-3	.878		
	Psd-4	.850		
	Psd-5	.886		
	Psd-6	.870		
	Total		*13.726*	*80.741*
Organizational Commitment	Factor 1 (continuance commitment		7.187	39.926
	Ccd-1	.914		

	Ccd-2	.907		
	Ccd-3	.912		
	Ccd-4	.910		
	Ccd-5	.887		
	Ccd-6	.882		
	Factor 2 (affective commitment)		4.266	23.699
	Acd-1	.872		
	Acd-2	.878		
	Acd-3	.894		
	Acd-4	.892		
	Acd-5	.889		
	Acd-6	.858		
	Factors 3 (normative commitment)		3.214	17.853
	Ncd-1	.860		
	Ncd-2	.896		
	Ncd-3	.882		
	Ncd-4	.887		
	Ncd-5	.831		
	Ncd-6	.860		
	Total		*14.667*	*81.478*
	Factor 1		6.140	43.855
	Itl-1	.891		
	Itl-2	.871		
	Itl-3	.855		
	Itl-4	.824		
	Itl-5	.826		
	Itl-6	.805		
Turnover	Itl-7	.768		
Intention	Itl-8	.792		
	Itl-9	.558		
	Factor 2		2.599	18.562
	Itl-10	.752		
	Itl-11	.768		
	Itl-12	.723		
	Itl-13	.695		
	Itl-14	.711		
	Total		*5.74*	*62.417*

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.

The principal component analysis for the instrument revealed the presence of three components: morality and fairness, role clarification, and power sharing with eigenvalues exceeding 1, explaining 77.65% of the variance. The results are congruent with the previous research of Den Hartog and De Hoogh (2008). All items in the three dimensions of original scale remained without exclusion because each item has loading factor of 0.5 or higher. The internal consistency of the composite scale was evaluated using Cronbach's alpha, yielding a coefficient of 0.919, which indicates excellent reliability. In the same way, to ensure the subscales of the Organizational

Commitment Instrument constructed and tested by Meyer & Allen (1997) are accurate, 18 items are subjected to principal components analysis.

The appropriateness of the data for factor analysis was demonstrated by a KMO value of 0.914, which is well above the acceptable threshold of 0.70. In addition, the statistically significant Bartlett's Test of Sphericity indicated that the correlation matrix was suitable for factor analysis. The extracted factors revealed loadings of 0.831 and above for all retained items (Table 1). The principal component analysis revealed the presence of three components: continuance, affective, and normative commitment with eigenvalues exceeding 1, explaining 81.478 % of the variance. These results are congruent with the previous study by Meyer & Allen (1997). All items in the three dimensions of original scale remained without exclusion because each item has loading factor above 0.5. A Cronbach's alpha of 0.834 indicates that the summative scale demonstrates satisfactory internal consistency.

Similarly, the turnover intention items developed by Roodt (2004), the 14 items are diagnosed *via* principal components analysis to verify their accuracy. The adequacy of the data for principal component analysis was examined before interpreting the extracted components. The KMO statistic was 0.905, which surpassed the recommended cut-off value of 0.70, while Bartlett's Test of Sphericity was statistically significant, confirming the suitability of the correlation matrix for factor analysis. Inspection of the correlation matrix revealed the presence of factor loading of .516 and above (Table 1). The principal component analysis for the instrument revealed the presence of two components: turnover intention 1, and turnover intention 2 with eigenvalues exceeding 1, explaining 62.42 % of the variance. The two components obtained are not consistent with previous research on the instrument by Roodt (2004). All items in the original scale remained without exclusion because each item has loading factor of greater 0.5. Internal consistency of the summative scale was confirmed by a Cronbach's alpha of 0.880, within the acceptable range.

2.4. Validity of the Instruments

Beyond reliability, three forms of validity were addressed. Content validity was established by adopting instruments from previously validated scales used extensively in the ethical leadership, organizational commitment, and turnover intention literature, with the questionnaire content reviewed by a subject-matter expert to confirm its relevance to the Ethiopian hospital context. Criterion-related validity was supported by the instruments demonstrated performance in prior

published studies using the same measurement models. Construct validity was confirmed through the principal component factor analyses reported above (Table 1), in which all retained items loaded above the 0.50 threshold on their theoretically expected dimensions.

Table 2: Reliability Estimates of Instruments Used in Previous Studies

Instrument	Sub-dimension	Original α
MCLQ (Ethical Leadership)	Morality and fairness	0.81
	Role clarification	0.88
	Power sharing	0.78
OCQ (Organizational Commitment)	Affective commitment	0.87
	Continuance commitment	0.75
	Normative commitment	0.79
TIQ (Turnover Intention)	…	0.913

Note: The reliability estimates shown above are those reported in the original validation studies for each instrument, presented for comparison with the reliability coefficients obtained in the present study (Cronbach's alpha of 0.919, 0.834, and 0.880 for ethical leadership, organizational commitment, and turnover intention respectively).

2.5. Model Specification

To formally test the mediating role of organizational commitment (OC) in the relationship between ethical leadership (EL) and turnover intention (TI), the following regression models were estimated, consistent with the causal-steps approach to mediation and corresponding to the results reported in Tables 10, 11, and 14:

$$\textbf{Model 1 (total effect):}\quad TI = \alpha_1 + c(EL) + e_1$$

$$\textbf{Model 2 (effect on mediator):}\quad OC = \alpha_2 + a(EL) + e_2$$

$$\textbf{Model 3 (direct and mediated effect):}\quad TI = \alpha_3 + c'(EL) + b(OC) + e_3$$

Where:

- c is the total effect of EL on TI (Table 10: B = -0.205, β = -0.245);
- a is the effect of EL on OC (Table 11: B = 0.290, β = 0.376);
- b is the effect of OC on TI, controlling for EL (Table 14: B = -0.315, β = -0.290); and
- c′ is the direct effect of EL on TI, controlling for OC (Table 14: B = -0.114, β = -0.136).

The indirect effect (a × b) was tested for significance using the Sobel test ($Z = -4.725$, $p < 0.001$). Since c′ remained statistically significant rather than reducing to zero, the results support partial rather than full mediation, which directly informs the interpretation of H_3 in the discussion below.

3. Results & Discussion

3.1. Demographic Characteristics of the Respondents

Table 3: Demographic Characteristics of Respondents

Variable		Frequency	Percentages
Gender	Male	175	43.1
	Female	231	56.9
Age	21-30 years	76	18.7
	31-40 years	203	50
	41-50 years	122	30
	>50 years	5	1.2
Marital Status	Single	137	33.7
	Married	269	66.3
Level of Qualification	Diploma in nursing	100	24.6
	BSc Nurse	187	46.1
	Medical doctor (General)	77	19
	Specialized doctor	42	10.3
Current Position	Nurse Staff	163	40.1
	Supervisor	106	26.1
	Doctor	81	20
	Middle Management	46	11.3
	Senior Management	10	2.5
Organizational Tenure	1-4years	166	40.9
	5-8 years	173	42.6
	9-12 years	58	14.3
	>12years	9	2.2
Job type (Ownership)	Public	306	75.4
	Private/NGO	100	24.6

Source: Own survey, 2025.

Table 3 above summarizes the demographic characteristics of the respondents, with most of the respondents are professional nurses (diploma and BSc nurse) accounting for nearly 70% respondents working in hospitals of the region. The survey accommodates more female respondent (56.9%) than male respondents (43.1%). At face value, it seems the proportion of female healthcare personnel in hospitals in Oromia region is higher than male healthcare personnel. Three hundred twenty-five respondents, accounting for 80 %, are at the age between 31 and 50. It is safe to conclude from descriptive statistics that the healthcare personnel in the hospitals of the region are fall within a mid-career age range, from 31 to 50 which account for 80% of the total health care personnel. Those at the age of 51 to 60 are rarely to be found. Most (83.5%) served hospitals in the region for eight or less years and only 2.2% of the respondents spent more than 12 years in hospital. 75.4% of health care professionals are from public hospitals; where as, 24.6% of them

are from private/NGO hospitals of the region. Statistical data indicate that most of hospitals operating in the region are of public owed, participation of private organizations and NGOs in this area is limited in the region.

3.2. Descriptive Statistics and Reliability of Study Variables

Table 4 presents the mean, standard deviation, and reliability (Cronbach's alpha) of ethical leadership, organizational commitment, and their respective dimensions, alongside the reliability estimates reported in the original validation studies for comparison. Each subject's score on a given dimension was computed as the mean of subject's ratings on the corresponding items.

Reliability estimates obtained in this study exceed those reported in the original validation studies for all ethical leadership and organizational commitment dimensions, while the turnover intention scale shows a reliability estimate marginally lower than, but still close to, its original benchmark; overall, these results indicate strong internal consistency of the instruments in the Ethiopian hospital context.

Table 4: Descriptive Statistics and Reliability Estimates of Study Variables (N = 406)

Variable	α (prior studies)	α (this study)	Mean	SD	Midpoint
Ethical Leadership (combined)	—	0.919	3.13	.837	3
Morality and fairness	0.81	.955	3.29	1.153	3
Role clarification	0.88	.941	3.19	1.111	3
Power sharing	0.78	.945	2.93	1.136	3
Organizational Commitment (combined)	—	0.834	3.15	.647	3
Affective commitment	0.87	.948	3.42	1.056	3
Continuance commitment	0.75	.963	2.94	1.258	3
Normative commitment	0.79	.944	3.10	1.091	3
Turnover Intention	0.913	0.886	3.14	.726	3

Source: Analysis result, 2025.

With regard to means, ethical leadership and its morality-and-fairness and power-sharing dimensions fall above the scale midpoint of 3, indicating that clinical staff generally perceive their supervisors as ethical leaders; however, the role clarification dimension (mean = 2.93) falls slightly below the midpoint, suggesting that supervisors are perceived as comparatively weaker at clarifying roles, responsibilities, and performance expectations. Similarly, while aggregate organizational commitment (mean = 3.15) and affective commitment (mean = 3.42) exceed the midpoint, continuance commitment (mean = 2.94) falls slightly below it, indicating that clinical

staff's attachment to their hospitals is driven more by affective and normative bonds than by a perceived cost of leaving. Turnover intention shows a mean of 3.14, above the scale midpoint, indicating that clinical staff generally hold some intention to leave their current hospital; its reliability in this study (0.886) is close to, though marginally lower than, the original estimate reported by Roodt (2004) (0.913).

3.3. Differences in Ethical Leadership Perception and Organizational Commitment

To connect the demographic profile of respondents (Table 3) directly to the study's key variables, independent-samples t-tests and one-way ANOVA were conducted to examine whether ethical leadership perception and organizational commitment differ significantly across demographic groups. The most consistent and substantively relevant differences emerged for marital status and organizational tenure, reported in detail below; differences by gender, hospital ownership, age, and academic qualification were also examined and are summarized narratively.

Table 5: Ethical Leadership and Organizational Commitment by Marital Status

Dimension	Single (Mean)	Married (Mean)	t	p
Morality and fairness	2.89	3.49	-5.089	0.000*
Role clarification	2.98	3.29	-2.659	0.008*
Power sharing	2.70	3.05	-3.001	0.003*
Affective commitment	2.99	3.64	-5.963	0.000*
Continuance commitment	2.40	3.22	-6.935	0.000*
Normative commitment	3.12	3.08	0.332	0.740

Legend: *p < 0.05.

Married clinical staff reported significantly higher scores than single staff on all ethical leadership dimensions, and on the affective and continuance commitment; normative commitment did not differ significantly by marital status.

Table 6: Ethical Leadership and Organizational Commitment by Organizational Tenure

Variable	1–4 yrs	5–8 yrs	9–12 yrs	>12 yrs	Sig.
Ethical Leadership (mean)	2.80	3.26	3.59	3.99	0.000*
Organizational Commitment (mean)	2.85	3.36	3.32	3.72	0.000*

Legenc: *p < 0.05; ANOVA, with Welch/Brown-Forsythe robust tests for the homogeneity-of-variance assumption.

Both ethical leadership perception and organizational commitment rose steadily with tenure, from clinical staff with 1–4 years of service to those with more than 12 years, consistent with the view

that longer-serving staff have had more opportunity to internalize their hospital's goals and to develop stronger relationships with supervisors.

Beyond marital status and tenure, several other demographic patterns emerged. Ethical leadership perception and organizational commitment both increased significantly with age, rising from a mean below the scale midpoint among staff aged 21–30 to the highest levels among staff over 50. Academic qualification was also associated with differences in ethical leadership perception, with general doctors reporting the lowest scores among all qualification groups. By gender, only the role clarification dimension differed significantly, with female staff reporting higher perceived role clarity than male staff; other ethical leadership and organizational commitment dimensions did not differ significantly by gender. By hospital ownership, only the power sharing dimension of ethical leadership and affective commitment differed significantly, both being higher among public and private hospital staff respectively. Together, these findings indicate that organizational tenure and marital status are the demographic factors most consistently associated with how clinical staff perceive ethical leadership and experience organizational commitment in Oromia regional hospitals.

3.4. Demographic Differences in Turnover Intention

Independent samples t-tests and one-way ANOVA were also conducted to examine whether turnover intention itself differs significantly across demographic groups, directly linking the demographic profile to the study's dependent variable.

Table 7: Turnover Intention by Gender and Marital Status

Grouping	Group A (Mean)	Group B (Mean)	t	p
Gender (Male / Female)	3.19	3.03	2.196	0.029*
Marital status (Single / Married)	3.30	3.00	4.235	0.000*
Hospital type (Public / Private)	3.08	3.16	-1.082	0.280

Legend: *p < 0.05.

Male staff reported significantly higher turnover intention than female staff, and single staff reported significantly higher turnover intention than married staff. Turnover intention did not differ significantly between public and private/NGO hospital staff, both groups reporting mean scores above the scale midpoint.

Table 8: Turnover Intention by Organizational Tenure and Age Group

Tenure group	1–4 yrs	5–8 yrs	9–12 yrs	>12 yrs
Turnover intention (mean)	3.26	3.11	2.67	2.90

Legend: ANOVA F = 10.978, p < 0.001.

Turnover intention was highest among staff with 1–4 years of tenure and lowest among staff with 9–12 years of tenure, indicating that turnover risk is concentrated among relatively new staff rather than rising steadily with tenure. By age group, turnover intention followed a broadly similar pattern, with the 41–50 age group reporting the lowest mean intention (2.89) and the 21–30 and 31–40 age groups reporting the highest (3.20 and 3.19 respectively; ANOVA F = 5.634, p = 0.001). Turnover intention did not differ significantly by academic qualification (F = 2.594, p = 0.052), although general medical doctors reported the only mean score falling below the scale midpoint.

3.5. Correlation Analysis

Based on review of previous literature, ethical leadership is hypothesized to be positively correlated with organizational commitment. The relationship is investigated by means of Pearson correlation analysis.

Table 9: Correlation among Variables

Variables	1	2	3	4	5	6	7	8	9
Ethical leadership (combined scale)	1								
Morality and fairness	.789**	1							
Role clarification	.629**	.284**	1						
Power sharing	.765**	.420**	.210**	1					
Organizational commitment (combined scale)	.376**	.457**	.192**	.164**	1				
Continuance commitment	.271**	.310**	.154**	.127**	.673**	1			
Affective commitment	.388**	.460**	.170**	.204**	.689**	.315**	1		
Normative commitment	-0.021	.009	.000	-.052	.335**	-.261**	-.106*	1	
Turnover intention	-.245**	-.240**	-.213**	-.094*	-.341**	-.317**	-.271**	.021	1

Legend: ** and * indicates that correlation (1-tailed) is significant at 0.01 and 0.05 level respectively.

As proposed in the hypothesis, the correlation result indicate that organizational commitment has strong positive correlation with ethical leadership (.376**) which confirm the acceptance of the first hypothesis. Among organizational commitment variables affective commitment has the strongest positive correlation with ethical leadership (average) (.388**) followed by continuance commitment (.271**) however normative commitment has no relation with ethical leadership (-.21). From ethical leadership variables, morality and fairness dimension has strongest correlation

with organizational commitment and its dimensions: (.457**) with organizational commitment (.460**) with affective commitment and (.310**) with continuance commitment.

Turnover intention is negatively associated with ethical leadership and its dimensions: (-.245**), with ethical leadership total (-.240**), moral and fairness dimension (-.213**), role clarification dimension and with power sharing dimension (-.094*), which is relatively weak association. Organizational commitment has significant negative correlation (-.341) with turnover intention as correlation table indicates. Comparing organizational commitment dimensions' correlation with turnover intention, continuance commitment has strong negative correlation (-.317) with turnover intention followed by affective commitment (-.271), however normative commitment has nearly zero relation with turnover intention (-.021) which is statistically insignificant.

3.6. Regression Analysis

Mediation analysis is conducted to test the last hypothesis, which state "the relation between clinical staffs' ethical leadership perception and their turnover intention will be fully mediated by organizational commitment." In doing so a series of procedures are followed: The first step involves regressing turnover intention (the dependent variable) on ethical leadership (the independent variable), with the requirement that ethical leadership emerges as a statistically significant predictor of turnover intention. Secondly, regressing independent variable (ethical leadership) on the proposed mediating variable (organizational commitment) once again ethical leadership must be significant predictor of organizational commitment. Table 10 and Table 11 present results of regression analysis for the above conditions respectively.

Table 10: Effects of Ethical Leadership on Turnover Intention

Model 1: Independent variable: *Ethical Leadership*	**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Error**	**Beta**		
Constant	3.745	.131			
Ethical Leadership (total)	-0.205	.040	-0.245	-5.077	0.000
R^2	0.060				
			F	25.776	0.000

a. Dependent Variable: *turnover intention*

Regression result in Table 10 shows that ethical leadership has statistically significant independent influence (β = -0.205) on turnover intention. 6% variation in turnover intention can be explained

by variation in ethical leadership. The negative regression coefficients indicate that there are inverse relationships between ethical leadership and turnover intention.

Table 11: Effects of Ethical Leadership on Organizational Commitment

Model 2 Independent variable: *Ethical Leadership*	**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Error**	**Beta**		
Constant	2.243	.116		19.410	.000
Ethical Leadership (total)	.290	.036	.376	8.145	.000
R^2	.141				
F				66.346	.000a

a. Dependent Variable: *organizational commitment*

It can be inferred from the finding in the table that ethical leadership is a significant predictor of organizational commitment (β = 0.290), explaining 14% variance in organizational commitment.

To identify which specific dimension of ethical leadership most strongly predicts organizational commitment, a stepwise multiple linear regression was conducted using the three ethical leadership dimensions (morality and fairness, role clarification, and power sharing) as predictors.

Table 12: Stepwise Regression of Ethical Leadership Dimensions on Organizational Commitment

Variable	**B**	**Beta**	**t**	**Sig.**
Constant	2.310	—	26.680	.000
Morality and fairness	.256	.457	10.317	.000

Legend: R = .457 R^2 = .209 SEE = .576 F = 106.445 Sig. F = .000

Only the morality and fairness dimension entered the model as a significant predictor of organizational commitment (B = .256, β = .457), explaining 21% of the variance; role clarification and power sharing did not add significant predictive value once morality and fairness was accounted for. This finding indicates that among the three ethical leadership dimensions, clinical staff's organizational commitment is driven primarily by their perception of supervisors' morality and fairness-their honesty, integrity, and even-handed treatment of staff, rather than by role clarification or participative decision-making. This result provides direct empirical support for the manuscript's recommendation that hospital leadership prioritize morality and fairness practices, such as transparent disciplinary processes and consistent, fair application of rules, as the primary lever for strengthening organizational commitment.

3.7. Direct Predictors of Turnover Intention

In parallel with the stepwise analysis for organizational commitment, a stepwise multiple linear regression was conducted to identify which specific ethical leadership and organizational commitment dimensions most directly predict turnover intention.

Table 13: Stepwise Regression of Ethical Leadership and Organizational Commitment Dimensions on Turnover Intention

Variable	B	Beta	t	Sig.
Constant	4.180	…	30.358	.000
Continuance commitment	-.134	-.240	-4.947	.000
Affective commitment	-.113	-.170	-3.496	.001
Role clarification	-.093	-.148	-3.151	.002

Legend: R = .392 R^2 = .154 SEE = .648 F = 24.370 Sig. F = .000

Turnover intention was significantly and negatively predicted by continuance commitment, affective commitment, and the role clarification dimension of ethical leadership, together explaining 15.4% of the variance; morality and fairness, power sharing, and normative commitment did not add significant predictive value. Notably, this differs from the pattern observed for organizational commitment, where morality and fairness appeared to be the dominant predictor (Table 12): turnover intention instead responds most strongly to the perceived cost of leaving (continuance commitment), emotional attachment (affective commitment), and role clarity. This suggests that while morality-and-fairness practices are most effective for building organizational commitment broadly, interventions aimed specifically at reducing turnover may need to additionally address role clarity and the practical and emotional costs of leaving, rather than relying on commitment-building alone.

Since the above two conditions hold; regression analysis that determine the effect of ethical leadership and organizational commitment together on turnover intention was conducted. For full mediation to existence; regression coefficient for organizational commitment should be significant, which is organizational commitment should be a significant predictor of turnover intention and regression coefficient for ethical leadership should be non-significant; its predictive value should be reduced to zero. If organizational commitment was a significant predictor of turnover intention and ethical leadership remains significant but reduced in its predictive value, the model indicates organizational commitment partially mediates the relation between ethical leadership and turnover intention. If the predictive value of ethical leadership remains significant

and not reduced from the original value of direct effect, the model shows that there is no indirect effect or mediation.

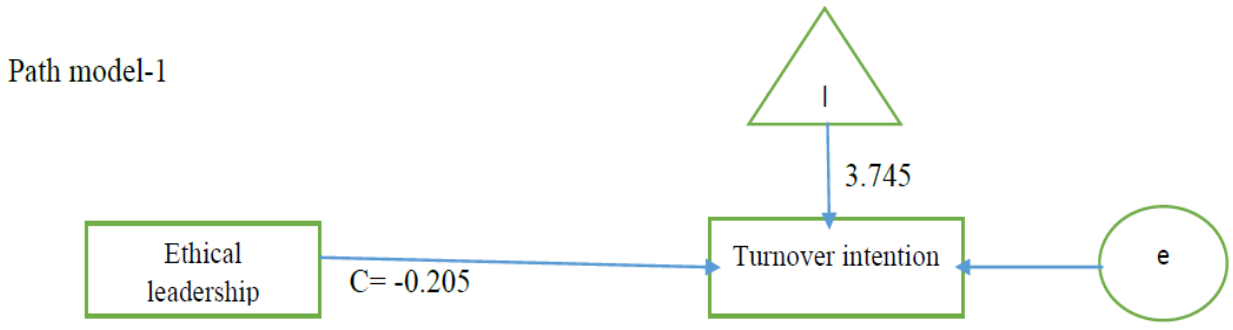
Table 14: Effects of Ethical Leadership and Organizational Commitment on Turnover Intention

Model 3: Independent variable: *Ethical Leadership* and *Organizational Commitment*	**Unstandardized Coefficients**		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Err.**	**Beta**		
Constant	4.451	.175		25.396	0.000
Ethical Leadership (total)	-0.114	.042	-0.136	-2.714	0.007
Organizational Commitment	-0.315	.054	-0.290	-5.799	0.000
R^2	0.132				
F				30.744	0.000

a. Dependent Variable: *turnover intention*

Regression results in Table 14 show that organizational commitment is statistically significant (meaningful) predictor (β = -0.315) of turnover intention and shows little reduction from the original predictive value (β = -0.370). Ethical leadership remains significant but reduced in its predictive value from (β = -0.205 to β = -0.114). It is a huge difference but still it needs to be reduced to zero to conclude the existence of full mediation. Hence it can be concluded that organizational commitment partially mediates the relation between ethical leadership and turnover intention. Therefore, the hypothesis that states the relation between ethical leadership and turnover intention is fully mediated by organizational commitment is not fully supported.

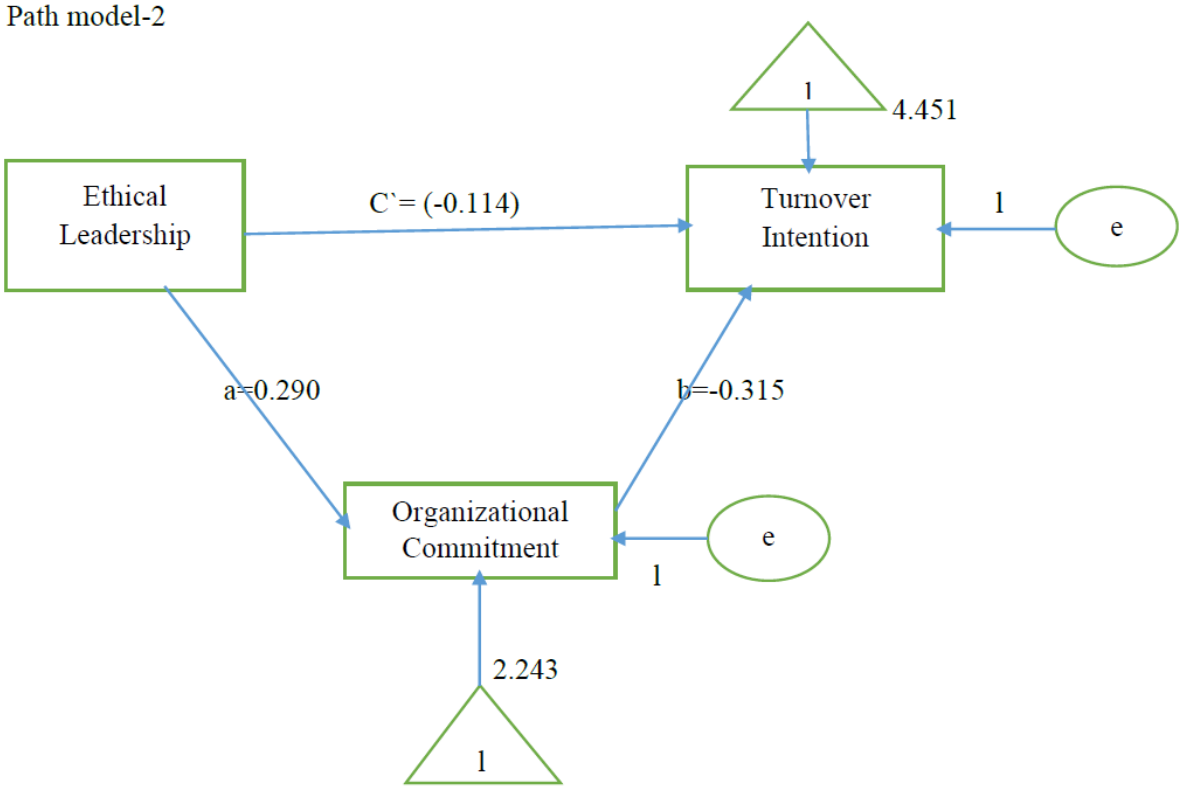
Figure-2 Illustration of Results Using Path Model



The results from path model reveal that the difference between the predictive values of direct path from ethical leadership to turnover intention before including mediation (C) was down from (β = -0.205) to (β = -0.114) after mediation variable is included. There is significant amount of difference between beta value of C and C`, however the path C` is statistically significant,

disproving the existence of full mediation. Hence, ethical leadership's relationship with turnover intention thus appears to operate partly through organizational commitment.

Path model-2



Notes:

- **Rectangles**: Observed Variables (Ethical leadership, organizational commitment and turnover intention)
- **Circles:** Unobserved Variables (e)
- **Triangles**: Constants
- **Arrows:** Associations
- a = unstandardized coefficient linking the independent variable to the mediator
- S_a = the standard error associated with a
- b = the coefficient linking the mediator to the dependent variable, controlling for the independent variable's direct effect on the outcome
- S_b = the standard error associated with b
- **C**= direct path from independent variable to dependent variable before including mediator
- **C`=** direct path from independent variable to dependent variable after including mediator

Further evidence to support the above conclusion was obtained by conducting SOBEL test. To conduct the test the values of a, Sa, b and Sb were inserted into an interactive calculation tool. As depicted in tables above the value of a= 0.290, Sa=0.036, b= -0.315 and Sb= 0.054. After putting these values into calculation, the following results were obtained: Z= (-4.725), p-value =

(0.00000231) the indirect effect is statistically significant which confirms the existence of mediation.

Conclusion and Recommendations

This study examined the relationship between ethical leadership perception and turnover intention among clinical staff in Oromia Regional State hospitals, Ethiopia's largest regional state, accounting for roughly 36.7% of the national population and 34.3% of its geographic area (ONRS, 2010) and tested whether this relationship is mediated by organizational commitment. The correlation results from the current research reaffirm earlier work by Brown et al. (2005), Rouzbahani et al. (2013), and Ponnu and Tennakoon (2009), all of which point to a positive association between ethical leadership and organizational commitment. Consistent with H_1 and H_2, ethical leadership perception was positively associated with organizational commitment and negatively associated with turnover intention; however, contrary to H_3, which proposed that organizational commitment would fully mediate this relationship, the results instead support partial mediation: the direct effect of ethical leadership on turnover intention ($\beta = -0.245$) remained statistically significant, though substantially reduced (to $\beta = -0.136$), once organizational commitment was included in the model. This finding matters specifically for Oromia's hospital workforce: strengthening ethical leadership perception meaningfully reduces turnover intention, but doing so through organizational commitment alone will not eliminate turnover risk, the continuance-commitment and role-clarity effects identified in this study (Table 13) point to additional levers hospital management must address directly, rather than relying on commitment-building as a single solution.

The demographic patterns observed further sharpen this picture for the regional context: ethical leadership perception, organizational commitment, and turnover intention all varied significantly by tenure and marital status, and turnover intention was concentrated among early-tenure and single clinical staff rather than rising steadily across the workforce. Given that Oromia's public hospitals rely heavily on early-career nurses and physicians, this suggests turnover risk in the region's hospitals is front-loaded in the first several years of employment — a pattern that regional human-resource retention strategy should treat as a distinct priority rather than folding into hospital-wide policy uniformly. A limitation of this study is its narrow focus on organizational commitment as the sole outcome examined in relation to ethical leadership, and its restriction to

physicians and nurses, who represent the two professional categories with the highest documented turnover in the Ethiopian health sector; subsequent studies would benefit from testing whether ethical leadership predicts other outcomes, and from extending this design to additional professional categories.

Based on the findings of this research, the following recommendations are given for hospital leadership and human-resource management in Oromia Regional State hospitals:

- ***Target morality and fairness practices as the priority lever***: Since morality and fairness showed the strongest correlation with organizational commitment and with turnover intention, hospital leadership across Oromia's District, Zonal, and Referral hospitals should prioritize interventions here first — e.g., transparent disciplinary processes, consistent application of rules across staff, and visible fairness in promotions and assignments.
- ***Close the power-sharing gap in private and NGO hospitals*:** Power-sharing perception was significantly lower among staff in Oromia's private/NGO hospitals than in public hospitals in this sample; owners and managers of private facilities are specifically advised to give clinical staff a genuine say in decision-making and to actively listen to their concerns, since this is the mechanism most likely to build trust and commitment in that setting.
- ***Design tenure-differentiated retention strategy, not blanket policy*:** Since turnover intention was highest among staff with 1–4 years of tenure and organizational commitment rose steadily with tenure, Oromia hospital administrations should treat early-tenure staff as a distinct retention priority — for example, through structured mentorship pairing new hires with longer-serving staff, rather than applying uniform HR policy across all tenure groups.
- ***Strengthen role clarity as a specific turnover-reduction lever*:** Because role clarification, not organizational commitment broadly, was a direct predictor of turnover intention, hospital administrations should develop and communicate clear, written role descriptions and performance expectations, particularly at District-level hospitals where supervisory spans tend to be widest.
- ***Strengthen affective and continuance commitment specifically, not commitment broadly*:** Since affective and continuance commitment — not normative commitment — drive the relationship with turnover intention, hospitals should invest in interventions that

build emotional attachment and perceived cost-of-leaving (career development pathways, recognition systems) rather than generic "commitment-building" programs.

- ***Use organizational commitment as the intervention pathway, not ethical leadership alone*:** Since organizational commitment mediates the ethical leadership–turnover intention relationship, hospital management should explicitly design ethical leadership initiatives through commitment-building mechanisms, rather than expecting ethical leadership training alone to reduce turnover.

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