Website: http: jebhpme.ssu.ac.ir
EISSN: 2538-4716
Evid Based Health Policy Manag Econ 2026; 10: 9-19
doi: 10.18502/jebhpme.v10i2.23158

ORIGINAL ARTICLE

The Relationship between Moral Intelligence, Emotional Intelligence, and Organizational Commitment among Employees in a Major Educational Hospital in Southeastern Iran

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Received: 23 August 2026 **Revised:** 19 October 2026 **Accepted:** 31 October 2026

A B S T R A C T

Introduction: A hospital, as an organization responsible for supplying and training skilled human resources, requires an environment where all employees possess desirable levels of moral intelligence (MI) and emotional intelligence (EI) and, particularly, organizational commitment (OC). Therefore, the objective of this study was to investigate the status and relationship between MI, EI, and OC among employees.

Materials and Methods: This research employed a cross-sectional and applied methodology. Using a stratified random sampling method, 397 participants were selected from Shahid Sadoughi Hospital in Yazd during 2025. To conduct this study, three standardized questionnaires were employed: the Moral Intelligence Scale by Lane and Kil (2005), the Emotional Intelligence Scale by Brackett and Salovey (2005), and the Organizational Commitment Scale by Allen and Meyer (1990). Data analysis utilized Pearson's correlation coefficients, the Kolmogorov-Smirnov test, independent samples t-tests, and ANOVA, all conducted using IBM SPSS Statistics version 27 (IBM Corp., Armonk, NY, USA).

Results: The results demonstrated a significant relationship between MI and OC ($r = 0.33$, $p < 0.001$). Similarly, EI showed a significant positive relationship with OC ($r = 0.44$, $p < 0.001$). Furthermore, MI and EI differed significantly by age group and work experience.

Conclusion: As MI and EI may be developable traits, organizations could consider implementing targeted educational programs and workshops to enhance these competencies among employees, which might potentially foster greater organizational commitment.

Keywords: Emotional Intelligence; Hospital; Moral Intelligence; Organizational Commitment

Citation: Rahimi MK, Shafaghat T, Jafari H, Banar N, Najafi R. **The Relationship between Moral Intelligence, Emotional Intelligence, and Organizational Commitment among Employees in a Major Educational Hospital in Southeastern Iran.** Evidence Based Health Policy, Management & Economics 2026; 10: 9-19.

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[DOI: 10.18502/jebhpme.v10i2.23158]

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Introduction

In today's dynamic world, organizations face complex challenges that profoundly affect their sustainability. In this regard, management based on ethical principles and mastery of Moral Intelligence (MI) has become an undeniable necessity for ensuring organizational survival. Adherence to these principles not only strengthens employees' morale but also, by improving the quality of services, leads to client satisfaction and, ultimately, organizational stability (1). Conversely, neglecting ethical issues in organizational management can create serious challenges (2), particularly when modern managers are confronted with complex problems arising from subordinates' failure to observe ethical standards. In such a context, MI emerges as an effective phenomenon to assist managers in resolving these problems. When an organization's leadership acts in accordance with ethical values, it demonstrates its commitment to the organization, resulting in superior performance in areas such as staff retention, reputation, and customer satisfaction (3). MI is, in fact, the ability to discern right from wrong and to behave based on universal principles, formed through the combination of the capacity for reasoning (intelligence) and guiding frameworks (ethics) (4). Since many individual behaviors are rooted in ethical values, weakness in adhering to these principles can undermine the legitimacy and performance of the entire organization (5).

Alongside ethical considerations, the management of emotions has also gained particular importance in modern organizations. Emotional Intelligence (EI), defined as the capacity to understand and control one's own emotions and those of others (6), has been recognized, since its introduction by Salovey and Mayer in 1990 (7), as one of the key instruments for human resource development. Today, organizations have realized that their competitive advantage lies not merely in technology, but in enhancing employees' self-confidence, commitment, and attachment to organizational goals (8). In this regard, possessing an energetic and committed human capital is considered one of the most vital resources; the absence of Organizational Commitment (OC) can lead to irreparable challenges for organizations (9). Identifying the level of commitment and the factors influencing it enables managers to reduce turnover, staff attrition, tardiness, and absenteeism by adopting measures to enhance employee engagement (10). OC reflects the degree of an individual's alignment with, and sense of belonging to, the organization (11).

This interplay between individual intelligences and organizational commitment takes on double significance in healthcare settings. Hospitals occupy a distinctive position owing to their sensitive nature and the fact that their performance is judged by the general public from both social and scientific perspectives. These organizations are responsible for training and supplying skilled human resources and require an environment in which all employees possess desirable levels of MI, EI, and, crucially, OC (12).While previous studies have extensively explored the individual associations of MI, EI, and OC within nursing staff and various healthcare settings, there is limited evidence regarding the concurrent examination of these three constructs across a diverse range of healthcare professional groups in large-scale educational hospitals. To address this, the present study aimed to investigate the correlational relationships among MI, EI, and OC among the diverse workforce at Shahid Sadoughi Hospital as a Major Educational Hospital in Southeastern of Iran**,** in Yazd. Specifically, this research sought to examine the current status of these variables and their inter-relationships to provide a comprehensive organizational profile of this high-pressure environment.

Materials and Methods

This study employed a cross-sectional and correlational design. The study population comprised all employees working in the various units (clinical, administrative, and paraclinical) of the hospital at Shahid Sadoughi Hospital in Yazd during 2025 .It comprises 431 beds and 29 wards, including 20 inpatient wards and 9 paraclinical departments.

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Participants

A proportional stratified random sampling method was employed, with the sample size allocated to each stratum based on its relative size. Consequently, the distribution of participants was as follows: 60 from the administrative section, 271 from the clinical section, and 70 from the paraclinical section.

To ensure sufficient statistical power to detect potentially subtle relationships between the psychological constructs (MI, EI, and OC) in the specific context of the Yazd healthcare setting, the sample size was determined based on an a priori power analysis using correlation as the primary analytical method. The calculation employed the following formula derived from established psychometric principles:

$$n = \left(\frac{Z_{1-\alpha/2} + Z_{1-\beta}}{C}\right)^2 + 3$$

where $C = \frac{1}{2}\ln\left(\frac{1+r}{1-r}\right)$.

Considering a small effect size ($r = 0.15$), an alpha level of 0.05 ($Z_{1-\alpha/2} = 1.96$), and a desired statistical power of 0.85 ($Z_{1-\beta} = 1.04$), the final analytic sample exceeded the minimum required sample of 397.

Data collection instruments

For this research, three standardized questionnaires were utilized:

A) Moral Intelligence: The 40-item questionnaire includes dimensions of integrity (13 items), responsibility (9 items), compassion (10 items), and forgiveness (8 items). Items were scored on a 5-point Likert scale, ranging from 1 (never) to 5 (always), with the following levels: 5 (always), 4 (often), 3 (sometimes), 2 (rarely), and 1 (never). The reliability of the entire questionnaire, assessed using Cronbach's alpha coefficient, was found to be 0.86, indicating high internal consistency. The face, content, and construct validity of the components were confirmed by subject matter experts (13).

B) Emotional Intelligence: The standardized Organizational Commitment Questionnaire, based on the model developed by Allen and Meyer (7), was utilized. This questionnaire contains 28 items divided into four dimensions: 6 items cover self-awareness, 9 items address self-management, 5 items pertain to social awareness, and 8 items relate to relationship management. In a separate study, Esmaeili and Ghodsi reported a reliability of 0.91 using Cronbach's alpha. To confirm content validity, the instrument was presented to subject matter experts, who were asked to rate the suitability of the questions for their respective dimensions using a five-point scale (completely appropriate, appropriate, relatively appropriate, inappropriate, and completely inappropriate). Necessary structural and formal revisions were then applied, confirming the tool's content validity (14).

C) Organizational Commitment: This standard questionnaire consists of 24 items, developed by the by Allen and Meyer (1990) (7) structured into three dimensions: 8 items concern affective commitment, 8 relate to normative commitment, and 8 cover continuance commitment (CC). In all three instruments, respondents were required to indicate their opinions using a Five-point Likert scale (always/very much, often/much, sometimes, rarely/little, never/no). The reliability of this questionnaire was assessed by Esmaeili and Ghodsi, yielding a Cronbach's alpha of 0.89. Content validity was confirmed through the same expert review process described above (14).

Statistical analysis

For data analysis, descriptive statistics were used, including frequencies and percentages for qualitative data, and central tendency measures (mean) and dispersion measures (standard deviation, range, variance) for quantitative data. To determine the scores for each dimension (MI, EI, and OC) and the overall scores, the mean of the items (questions) belonging to each respective dimension was calculated.

The normality of the data was assessed using the Kolmogorov-Smirnov test. The results indicated that the distribution of MI ($D = 0.06, p = .403$),

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MI ($EI = 0.144, p = .519$), OC ($D = 0.172$, $p = .333$), were normal. To examine differences in research dimensions based on demographic variables, Independent Samples t-tests were conducted for gender comparisons, while One-Way Analysis of Variance (ANOVA) was employed to assess differences across education levels, age, and work experience. Following the assessment of data normality, Pearson correlation coefficients were utilized to evaluate the relationships between the research dimension. Statistical analyses were performed using IBM SPSS Statistics version 27 (IBM Corp., Armonk, NY, USA) at a significance level of $\alpha = 0.05$.

Results

Regarding gender distribution, females predominated across all three sectors: clinical (57.70%), administrative (60%), and paraclinical (55.7%). In terms of educational attainment, the majority of clinical staff held a Master's degree (88.6%), while PhD holders represented the smallest group (5.5%). In the administrative sector, Master's degrees were also the most prevalent (53.3%), whereas the paraclinical sector was primarily composed of individuals with a Bachelor's degree (94.3%). Age-wise, the clinical sector was predominantly composed of individuals under 30 years of age (43.5%), with the 40–50 age group being the least represented (22.2%). In the administrative sector, the 30–40 age group was the most frequent (46.7%), while those under 30 accounted for the minority (10%). Similarly, in the paraclinical sector, individuals under 30 years old predominated (44.3%), with the 40–50 age group being the least common (22.9%). Regarding work experience, most participants in the clinical (36.5%) and paraclinical (44.3%) sectors had less than 5 years of experience. In contrast, the administrative sector was characterized by a higher prevalence of 5–10 years of experience (26.7%). The least frequent work experience in both clinical and administrative sectors was over 25 years (3.3% each), while in the paraclinical sector, those with over 25 years of experience represented 5.7% of the cohort.

Table 1. Descriptive statistics of the dimensions related to the studied variables

Dimensions	Mean ± SD	CI [Lower, Upper]
Integrity	3.98 ± 0.52	[3.93, 4.03]
Responsibility	3.99 ± 0.60	[3.93, 4.05]
Caring/compassion	4.03 ± 0.56	[3.97, 4.09]
Forgiveness	3.57 ± 0.66	[3.51, 3.63]
Moral Intelligence	3.91 ± 0.46	**[3.86, 3.96]**
Self-Awareness	3.88 ± 0.65	[3.82, 3.94]
Self-Management	3.66 ± 0.57	[3.60, 3.72]
Social Awareness	3.71 ± 0.61	[3.65, 3.77]
Relationship Management	3.73 ± 0.62	[3.67, 3.79]
Emotional Intelligence	3.77 ± 0.49	**[3.72, 3.82]**
Affective Commitment	2.86 ± 0.73	[2.79, 2.93]
Normative Commitment	2.94 ± 0.80	[2.86, 3.02]
Continuance Commitment	3.17 ± 0.63	[3.11, 3.23]
Organizational Commitment	2.99 ± 0.72	**[2.92, 3.06]**

As shown in Table 1, the Caring/compassion dimension yielded the highest mean score among the MI dimensions, while self-awareness emerged as the highest-scoring dimension within the EI category. Finally, among the dimensions of OC, the CC dimension secured the highest mean score. The overall mean scores were 3.91 ± 0.46 for MI, 3.77 ± 0.49 for EI, and 2.99 ± 0.72 for OC.

The results presented in Table 2 indicate that MI and EI scores did not differ significantly by gender or educational level (MI: gender $p = 0.41$, education $p = 0.33$; EI: gender $p = 0.09$, education $p = 0.22$). However, MI scores differed significantly by age group ($p = 0.04$) and work experience ($p = 0.02$). However, MI scores differed significantly by age group ($p = 0.04$) and work experience ($p = 0.02$).

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Specifically, individuals in the 40–50 age group (3.99 ± 0.60) and those with more than 25 years of work experience (4.01 ± 0.51) received the highest mean scores for MI compared to other groups. EI also differed significantly by age group (p = 0.04) and work experience (p = 0.01). Conversely, individuals under 30(3.76 ± 0.46) and those with less than 5 years of work experience (3.77 ± 0.46) received the highest mean scores for EI compared to other groups.

Furthermore, OC scores differed significantly by age group (p = 0.03) and work experience (p < 0.001), but not by gender (p = 0.49) or educational level (p = 0.22). Although OC did not differ significantly by educational level (p = 0.22), the highest descriptive mean score for OC was observed in participants with a bachelor's degree (3.02 ± 0.65). Among age and work-experience categories, the highest mean scores were observed in the 40–50 age group (3.12 ± 0.63) and those with less than 5 years of work experience (3.84 ± 0.59).

Table 2. Comparison of studied dimensions across demographic groups

Demographic Variable	Category	MI Mean ± SD	P-value	EI Mean ± SD	P-value	OC Mean ± SD	P-value
Gender	Female	3.93 ± 0.46	0.41	3.72 ± 0.52	0.09	2.98 ± 0.61	0.49
	Male	3.89 ± 0.45		3.82 ± 0.42		3.01 ± 0.64	
Age	< 30	3.93 ± 0.39	0.04	3.76 ± 0.46	0.04	2.90 ± 0.63	0.03
	30 to 40	3.84 ± 0.40		3.61 ± 0.46		2.99 ± 0.59	
	40 to 50	3.99 ± 0.60		3.63 ± 0.56		3.12 ± 0.63	
Education	Bachelor's	3.91 ± 0.49	0.33	3.66 ± 0.50	0.22	3.02 ± 0.65	0.22
	Master's	3.99 ± 0.26		3.67 ± 0.40		2.90 ± 0.42	
	PhD	3.82 ± 0.34		3.89 ± 0.51		2.60 ± 0.26	
Work Experience	< 5 years	3.84 ± 0.55	0.02	3.77 ± 0.46	0.01	3.84 ± 0.59	< 0.001
	5 to 10	3.85 ± 0.58		3.58 ± 0.48		3.04 ± 0.62	
	10 to 15	3.88 ± 0.56		3.75 ± 0.41		3.20 ± 0.65	
	15 to 20	3.90 ± 0.60		3.64 ± 0.48		3.09 ± 0.62	
	20 to 25	3.96 ± 0.57		3.56 ± 0.63		3.07 ± 0.67	
	>25 years	4.01 ± 0.51		3.76 ± 0.11		2.83 ± 0.25	

Note. MI = Moral Intelligence; EI = Emotional Intelligence; OC = Organizational Commitment. Data are presented as mean ± SD. Between-group comparisons were performed using one-way ANOVA. For variables with a significant omnibus test (age group and work experience for MI, EI, and OC), post hoc pairwise comparisons were conducted using **Tukey's HSD test**. When Levene's test indicated unequal variances, Games–Howell post hoc tests were applied. No post hoc test was required for gender because it comprised only two groups. Education was not significantly associated with MI, EI, or OC; therefore, no post hoc comparisons were performed for education

Finally, Pearson correlation analysis (not presented in Tables 1–2) demonstrated a significant positive relationship between MI and OC (r = 0.33, p < 0.001). Similarly, EI showed a significant positive relationship with OC (r = 0.44, p < 0.001).

Discussion

The findings of this research indicate that, overall, the mean scores for MI (3.91 ± 0.46) and EI (3.77 ± 0.49) were relatively high, whereas OC (2.99 ± 0.72) was at a moderate level. It should be noted, however, that using the conventional 5-point Likert interpretation (1.00–2.33 low, 2.34–3.66 moderate, 3.67–5.00 high), MI (3.91 ± 0.46) and EI (3.77 ± 0.49) actually fell within the high range, whereas only OC (2.99 ± 0.72) was truly moderate. This pattern is broadly consistent with Mehralian et al. (15) , who reported moderate MI and EI but low OC among nurses, suggesting that commitment may lag behind moral and emotional competencies in healthcare.(Using the conventional criterion for a 5-point Likert scale (1.00–2.33 = low, 2.34–3.66 = moderate, 3.67–5.00 = high), MI and EI fell within the high range and OC within the moderate range. Furthermore, MI showed a significant positive relationship with OC. These findings align with the study conducted by Panahi and Kakavand, which investigated the effectiveness of MI-based training components on the OC of military personnel in an armed forces unit. In their research, they concluded that applying MI training components in the workplace can be effective in promoting moral

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intelligence factors as well as increasing awareness and enhancing OC among employees (16). Supporting these results, studies by Khosravani et al. (17), Dehghan Maneshadi (18), and Dehghani Firozabadi et al. (19) are also consistent with the findings of the current research. More recently, Nazaripour et al. (20) extended this line of evidence to accountants and demonstrated that MI and EI jointly predict both OC and job performance, indicating that the MI–OC link is not confined to healthcare(. To explain this finding, it can be noted that MI signifies a deeper self-awareness as a non-material being. In essence, it is a source of latent, yet-to-be-discovered non-objective talents. MI assists individuals, much like a GPS system in a car, in navigating life's journey.

The research findings also show that, generally, EI has a significant relationship with OC in the entire study sample. This outcome is consistent with the findings of Davoudi et al., who examined the impact of EI skills training on the OC of nurses in university hospitals in Birjand. They concluded that utilizing EI skills training strategies can enhance nurses' commitment and loyalty to their organization and professional institution (21). In further support of the current study's results, the works of Alsughayira (22), Mahanta and Goswami (23), Shafiq and Akram Rana (24), Ates and Buluc (25), and Antony (26) can be cited, all of which corroborate the findings of this research. Contemporary meta-analytic evidence reinforces this conclusion: Doğru (2022) reported a moderate positive association between EI and organizational commitment across primary studies, and Negrușescu (28) reached a similar conclusion in a meta-analytic review, suggesting that the EI–OC relationship is robust across sectors and cultural contexts. To explain this finding, it can be stated that acquiring the intrapersonal and interpersonal skills of EI enables individuals in the workplace to better understand each other and cope with the specific situations and circumstances of their colleagues. This process allows them to integrate into the group while maintaining individual autonomy and participating effectively in teamwork. These factors contribute to making the organizational environment more desirable for employees, thereby increasing their job satisfaction and, consequently, enhancing their attachment to the job and their commitment to the entire organization (29). In the new approach to organizational culture management, teamwork and the manner of collaboration within the organization hold particular importance, and organizations prioritize employees who possess social capabilities and communication skills, who are both good listeners and speakers, and who effectively manage the expression and transmission of feelings by understanding their own and others' emotions (30). OC is a primary job attitude that governs other behavioral and attitudinal approaches of employees. Teamwork and interpersonal relationships within the organization can also lead to and improve OC. This association may partly depend on EI, as individuals with low EI may struggle with group and interpersonal communication, which in turn may diminish their OC (31). However, given the cross-sectional design, causal direction cannot be established.

An additional finding worth highlighting is the relatively lower mean of OC (2.99) compared with MI and EI, with Continuance Commitment (3.17) emerging as the highest OC dimension. This suggests that employees' attachment to the organization may be driven more by perceived switching costs and pragmatic considerations than by affective bonds. A recent study of nurses in Saudi Arabia similarly reported moderate levels of affective, normative, and continuance commitment, and identified interdisciplinary collaboration and resource adequacy—rather than individual emotional competencies alone—as consistent predictors of commitment. This implies that individual-level MI and EI, while important, operate within a broader organizational environment; supportive practice environments and participatory leadership may be necessary conditions for translating moral and emotional competencies into affective commitment (32)

This research indicates that MI did not differ

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significantly by gender or education level. However, MI differed significantly by age group and work experience. Individuals in the 40–50 age group and those with more than 25 years of work experience received the highest mean scores for MI compared to other groups. This age-related increase in MI is theoretically plausible: lifespan research indicates that moral reasoning and the capacity to integrate ethical considerations into decisions continue to develop well into adulthood, and older employees with longer organizational tenure tend to demonstrate higher moral reasoning and more responsible decision-making. In contrast, younger employees may prioritize immediate rewards, which can constrain the application of moral judgment in work settings. Mehralian et al. (2024) similarly found that MI scores increased significantly with age and work experience among nurses, with the more than 40 age group and 20 years of experience scoring highest (15). In the study by Talebi Ghadicolaei et al., which examined the relationship between MI and job burnout among pre-hospital emergency staff in Mazandaran during the COVID-19 pandemic, the results showed that gender, marital status, education, employment type, shift, and work history were significantly related to the MI score, but there was no significant relationship between age and MI score (33). The commonality between the current study and that of Talebi Ghadicolaei et al. is that MI differed significantly by work experience in both studies. The discrepancy regarding age may also reflect differences in the occupational context: pre-hospital emergency staff work in highly protocol-driven, time-pressured environments in which age-related moral maturation may be less visible, whereas the present sample included clinical, administrative, and paraclinical staff whose roles may allow greater expression of moral judgment. The discrepancy in the results of these two studies can be attributed to differences in the size and socio-cultural context of the research samples.

This study's results suggest that EI did not differ significantly by gender or education level. However, EI differed significantly by age group and work experience. Interestingly, individuals under 30 and those with less than 5 years of work experience received the highest mean scores for EI compared to other groups. This pattern—higher EI in younger and less-experienced employees—has also been reported in Iranian organizational samples. A study of transmittal company employees found that the 22–30 age group scored significantly higher on EI than the 31–40 and more than 41age groups. Several explanations may account for this: younger employees may have been exposed to more recent emotion-related training during their education, may be more open to feedback and reflective learning, and may face stronger early-career pressures to adapt emotionally to the workplace. Additionally, this may reflect a cohort effect rather than a developmental decline, and cross-sectional designs cannot distinguish between the two. In the study by Amirghodsi and Bonyadi Naeini, which investigated the relationship between EI, OC, and job satisfaction and the demographic characteristics of employees in the Iranian Central Oil Fields Company, the results showed that gender, age, and work history were significantly related to the EI score, but there was no significant relationship between education level and EI score (34). The common ground between the current research and the study by Amirghodsi and Bonyadi Naeini is that in both studies, EI differed significantly by age group and work experience but not by education level. At the same time, the inverse age gradient observed here contrasts with studies that report increasing EI with age. This divergence may be explained by the specific composition of our sample, in which younger staff were predominantly employed in paraclinical roles (94.3% held a Bachelor's degree) and may have been exposed to structured, emotion-focused curricula, whereas older staff were more concentrated in clinical and administrative positions where emotional demands differ. Occupational role, rather than age per se, may therefore be a key moderator. The differences in the results of these two studies can be attributed to

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the differences in the sample size, social culture, and the specific organization under investigation. Although the sample included clinical, administrative, and paraclinical staff, sector-level differences were descriptive only and were not formally tested; therefore, no inferential claims are made regarding sector.

The results of the present study indicate that OC differed significantly by age group ($p = 0.03$) and work experience ($p < 0.001$), but not by gender ($p = 0.49$) or education level ($p = 0.22$). Descriptively, participants in the 40–50 age group (3.12 ± 0.63) and those with less than 5 years of work experience (3.84 ± 0.59) had the highest mean OC scores; although bachelor's degree holders also showed a numerically higher mean (3.02 ± 0.65), this difference was not statistically significant. The early-career peak in OC is consistent with the well-documented honeymoon–hangove pattern, in which enthusiasm and loyalty are relatively high at organizational entry, decline during mid-career, and may rebound later. The 40–50 age group may represent a stage in which employees have consolidated their professional identity and achieved a stable balance between work demands and personal resources, whereas employees with 10–20 years of tenure may experience mid-career plateau and routine that temporarily depress commitment. It is also notable that the lowest descriptive OC mean in our sample was observed among employees with more than 25 years of experience (2.83 ± 0.25) and among PhD holders (2.60 ± 0.26); however, these subgroups were small, and the education-related difference did not reach statistical significance ($p = 0.22$), so these observations should be interpreted cautiously. Amirghodsi and Bonyadi Naeini reported significant differences in OC across age, education, and work history (34), our findings are consistent with respect to age and work history but not education. Our findings converge with theirs regarding age and work history but diverge regarding education; this divergence may reflect limited statistical power in the small Master's and PhD subgroups rather than a substantive difference, and future studies with larger and more balanced educational subgroups are needed. although the sample was drawn from three sectors clinical, administrative, and paraclinical sector-level differences were descriptive only and were not formally tested. The literature suggests that the nature of work, role responsibilities, and routine practices differentiate hospital staff groups and may shape how emotional and moral competencies translate into commitment. Future multi-group analyses with adequate sector-specific sample sizes would be valuable to determine whether the MI–OC and EI–OC relationships are moderated by occupational sector.

Conclusion

The findings of the present study demonstrated significant positive correlations between Moral Intelligence (MI), Emotional Intelligence (EI), and Organizational Commitment (OC). Specifically, higher levels of MI and EI were significantly associated with higher levels of OC. Additionally, the results indicated significant differences in MI and EI scores based on participants' age and work experience. In contrast, no significant associations were found between gender, education level, and organizational commitment. These results suggest that moral and emotional competencies are key factors related to organizational commitment within the studied population. Therefore, organizations should consider these dimensions when developing human capital strategies to enhance commitment and professional engagement.

Suggestions

- Based on the research findings, human resource managers of the organization should seriously include educational topics and programs aimed at improving employees' MI and EI in their agenda.
- Managers should employ appropriate techniques during recruitment to attract individuals who possess high MI and EI.
- Organizational managers can take action to enhance employees' self-awareness and OC by

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organizing training classes on personal care and holding sessions focused on increasing awareness of emotions and feelings.

- Given that OC was moderate and lowest among long-tenured employees (> 25 years) and PhD holders, managers should consider tailored retention and engagement strategies for these groups, such as career development opportunities and recognition programs.

Limitations

This study, while providing valuable insights into the associations between MI, EI, and OC, is subject to several limitations that should be considered when interpreting the findings. Firstly, the cross-sectional design of the study precludes establishing definitive causal relationships. The authors observed associations between the constructs, suggesting that higher MI and EI are linked to greater OC, but they cannot infer that MI and EI directly cause changes in OC. Future longitudinal research is needed to explore the temporal dynamics and potential causal pathways. Secondly, the reliance on self-report questionnaires for all major constructs (MI, EI, and OC) at a single time point introduces potential methodological challenges. Common-method bias may also inflate or deflate the observed correlations, as the variance related to the measurement method itself could be shared across variables. To mitigate this, the researchers emphasized the anonymity and confidentiality of responses and ensured that validated scales with demonstrated psychometric properties were used for each construct. Nevertheless, the possibility of shared method variance remains. Furthermore, social desirability bias is a potential concern, where participants may respond in a manner that they perceive as favorable or socially acceptable. While anonymity was stressed, the authors cannot fully eliminate this influence. Finally, the possibility of residual confounding exists, as unmeasured variables (e.g., organizational culture, leadership style, specific job demands) could influence the relationships between MI, EI, and OC. While the researchers controlled for age and work experience, other confounding factors may be present. The authors acknowledge these limitations and emphasize that the findings should be interpreted as indicative of associations within the studied context, rather than conclusive evidence of causality or universal applicability.

Authors' Contributions

MK.R and H.J conceptualized and designed the study, prepared the initial manuscript draft, and contributed to manuscript revisions; MK.R supervised the research process; T.Sh and N.B contributed to data collection; R.N conducted the statistical analyses and contributed to data interpretation. All authors reviewed and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

Acknowledgments

This study was supported by the Research and Technology Vice-Presidency of Shahid Sadoughi University of Medical Sciences, Yazd, under project number 17281. We would like to express our gratitude to all the participants who assisted us by completing the questionnaires.

Competing Interests

The authors declare no competing interests.

Data Availability Statement

The data supporting this study are available from the corresponding author only on reasonable request.

Ethics Considerations

For conducting the research, an ethics code (IR.SSU.SPH.REC.1403.053) was obtained from the Research Ethics Committee of Shahid Sadoughi University of Medical Sciences. Efforts were also made to ensure the confidentiality of all information. Informed consent for participation in the research was also secured by explaining the study objectives, the manner of cooperation, the method of data collection, and the roles of the researcher and the participants. All procedures were conducted in accordance with the Declaration of Helsinki.

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[DOI: 10.18502/jebhpme.v10i2.23158]

Funding
This study was supported by Shahid Sadoughi University of Medical Sciences.

Artificial Intelligence Use Disclosure Statement
Artificial intelligence was used to enhance the English language and readability of this manuscript. The authors have reviewed and edited the final text to ensure accuracy.

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