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The Role of Organizational Citizenship Behavior in Healthcare Sector Performance

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ABSTRACT

Organizational Citizenship Behavior (OCB) encompasses voluntary, extra-role behaviors that extend beyond formal job descriptions. In stressful, patient-centric healthcare environments, OCB dimensions, specifically altruism, conscientiousness, sportsmanship, civic virtue, and courtesy, are fundamental to clinical agility, interprofessional collaboration, and quality healthcare outcomes. This study assesses the role of organizational drivers and the performance impacts of OCB across the healthcare sector in a district in Tamil Nadu, India. Using a stratified cross-sectional design, primary data were collected from 210 healthcare professionals during June- July 2026. The findings showed a strong positive relationship with OCB dimensions, with the highest correlations with conscientiousness ($r = 0.71$, $p < 0.001$) and Clinic virtue ($r = 0.68$, $p < 0.001$). Leadership styles significantly influenced OCB engagement levels (Chi-square = 31.82, $p = 0.0004$), with transformational leadership driving high OCB observations. Job design parameters accounted for 41.2% of the total variance ($p < 0.001$), Peer & Team Information Exchange (loading 0.86) and Supervisory Feedback (loading 0.82) are the primary catalysts for extra-role behavior. The study found that high-performance workplace systems produce significantly higher overall OCB mean scores compared to standard operational environments.

Keywords: Organizational Citizenship Behavior, Healthcare Sector, Transformational Leadership, Job Design, Employee Empowerment.

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INTRODUCTION

Organizational Citizenship Behavior (OCB) refers to discretionary employee actions that extend beyond formal job requirements (Organ, 1988). These behaviors are voluntary and fall outside official workplace reward systems. Because OCBs are non-contractual, failing to perform them does not result in any formal disciplinary action. However, when aggregated across an organization, these individual efforts significantly enhance operational efficiency. In practice, OCB reduces internal friction, boosts workforce morale, and fosters organizational synergy. Understanding the mechanisms that drive OCB remains vital for modern organizational performance (Anindita & Bachtar, 2021).

In healthcare delivery, reliance on extra-role behavior is a daily operational reality. High cognitive loads, unforeseen clinical emergencies, strict compliance mandates, and tight interdisciplinary dependencies characterize these environments (Sun *et al.*, 2025). Clinical and non-clinical staff frequently perform discretionary tasks such as staying past shift end to stabilize a patient, voluntarily mentoring junior nurses, or resolving administrative bottlenecks—actions that directly affect patient safety and operational performance (Ocampo *et al.*, 2018).

Studies have shown that organizational inputs such as organizational strategies, leadership styles, and workplace designs serve as foundational inputs that shape employee behaviors and attitudes. Zhou *et al.* (2025) argued that empowering and inclusive leadership styles contribute to staff operational autonomy by building psychological safety and trust in leadership. Hackman & Oldham (1976) found that crafting roles rich in autonomy, task significance, and feedback increases intrinsic work motivation and overall employee engagement. According to Sott & Bender (2025), open, transparent, and multi-directional communication channels lower workplace anxiety and strengthen perceived organizational support. An earlier study by Blau (1964) recognized that individual and group achievements reinforce extra-role behavior through principles of social exchange. Studies by Hafeena *et al.* (2024) and Suwandi *et al.* (2026) showed that integrating selective hiring, continuous training, and digital HR practices elevates organizational commitment and overall workforce quality.

Discretionary, extra-role behaviors displayed by healthcare providers, categorized under Organ's 5-factor model (Organ, 1988): (i) Altruism: voluntarily helping colleagues manage excessive workloads or clinical emergencies without expecting direct compensation; (ii) conscientiousness: exceeding required attendance, safety standards, and protocol thoroughness in daily clinical practice, (iii) sportsmanship: maintaining a positive, resilient attitude and tolerating operational disruptions without complaining, (iv) civic Virtue: actively participating in hospital governance, continuous quality improvement committees, and policy reviews and (v) courtesy: taking proactive steps to resolve team friction, coordinate workflows smoothly, and show empathy.

The macro-level clinical and structural performance outcomes resulting from widespread OCB may include Clinical Operational Agility: the institution's capacity to adapt rapidly to unexpected patient surges, health crises, or changing care guidelines (Steeh *et al.*, 2025). Patient Satisfaction: Higher overall care ratings and improved patient experience stemming directly from dedicated staff citizenship behavior (Sun *et al.*, 2025). Further, it enhances organizational capacity to absorb operational shocks, minimize burnout, and sustain continuous care delivery (Soelton *et al.*, 2023).

In India, Tamil Nadu's healthcare sector is widely recognized for its high health indicators, including low infant and maternal mortality rates alongside high life expectancy—often cited as the "Tamil Nadu Model of Health." However, maintaining these achievements amidst changing demographic profiles, rising chronic disease rates, and workforce stress requires continuous organizational optimization. Physical infrastructure alone cannot sustain clinical excellence; the voluntary effort and citizenship behaviors of healthcare personnel remain vital. This study provides an updated empirical assessment of how structural, managerial, and environmental factors influence OCB among healthcare professionals in the state.

LITERATURE REVIEW

Recent literature highlights the key role of strategic human resource management, leadership dynamics, and organizational climate in driving extra-role behaviors (OCB).

Perceived organizational systems and structural support serve as foundational drivers for discretionary workplace behaviors.

Hafeena *et al.* (2024) demonstrated that perceived strategic HRM practices—specifically structured recruitment, continuous training, fair reward distribution, and clear career progression—significantly boost employee retention, with OCB serving as a critical mediating variable. Building on structural frameworks, Soelton *et al.* (2023) confirmed that internal communication structures and Perceived Organizational Support (POS) enhance employee motivation, which directly translates into increased OCB. In high-stress clinical settings, clear communication channels reduce role ambiguity and foster voluntary cooperation.

Leadership characteristics directly shape the extent to which employees exhibit team-oriented and citizenship behaviors. Kalargyrou *et al.* (2023) established that supervisor personality traits and empathetic leadership styles significantly influence team citizenship behaviors. Similarly, focusing on the leadership-satisfaction relationship, Dubey *et al.* (2023) demonstrated that transformational leadership buffers workplace stress and fosters high levels of job satisfaction and OCB. Conversely, negative supervisory behaviors severely impair extra-role performance; Mahmoud *et al.* (2023) showed that abusive supervision degrades employee psychological well-being, leading to a direct decline in individual-directed OCB (OCBI). Beyond structural and leadership drivers, internal psychological states significantly govern voluntary effort. Merdiaty *et al.* (2023) established that "meaningful work" fully mediates the relationship between organizational commitment and extra-role behaviors, showing that when healthcare professionals perceive personal purpose in their work, their willingness to exhibit OCB increases independently of monetary incentives.

Despite these empirical insights, a significant gap remains in understanding how dual public-private health system dynamics moderate OCB compared to findings in developed countries. OCB research primarily examines standardized, single-sector or insurance-backed healthcare environments with stable resource allocations (Podsakoff *et al.*, 2019). Health systems in developing countries differ starkly. In developing countries like India, government healthcare facilities operate under severe resource constraints, extreme patient volume, and high procedural vagueness, whereas private hospitals administer corporate accountability, rigid metrics, and profit-driven performance expectations.

Building upon these theoretical foundations, this study presents a revised empirical evaluation of OCB drivers within the healthcare sector of Tamil Nadu. Understanding OCB within this health system is critical, as the state operates one of India's most expansive, high-volume public and private healthcare models, where operational efficiency heavily relies on staff discretionary effort. Tamil Nadu's high patient turnover, complex public health mandates, and rapid digital health integration create intense workplace pressures that make rigid job descriptions insufficient for daily continuity of care. Investigating OCB in this regional context illuminates how local leadership styles, strategic HR practices, and organizational support can reduce clinical burnout, lower turnover, and foster voluntary collaboration among healthcare workers. Hence, establishing these empirical drivers provides Tamil Nadu health administrators with actionable strategies to enhance patient safety, optimize service delivery, and maintain resilient public health infrastructure.

Research Questions

1. How does employee empowerment affect the five individual dimensions of OCB among healthcare staff?
2. To what degree do transformational, transactional, and laissez-faire leadership styles differentiate employee OCB engagement levels?
3. What proportion of OCB variance is predicted by structural job design parameters in healthcare facilities?
4. Which internal communication dimensions serve as the primary drivers of voluntary extra-role behaviors?
5. How do structured recognition and formal reward systems interact to influence employee OCB scores?
6. Does the implementation of High-Performance Workplace Systems (HPWPs) yield a statistically significant elevation in OCB mean scores compared to standard management systems?

Hypotheses

- H1: Employee empowerment positively influences the core dimensions of OCB among healthcare personnel.
- H2: Leadership styles significantly influence OCB engagement levels in healthcare facilities.
- H3: Job design parameters significantly predict OCB levels across healthcare organizations.
- H4: Internal communication practices positively impact employee OCB scores.

H5: Recognition and reward systems exert a significant positive effect on employee OCB.

H6: High-performance workplace practices significantly increase overall employee OCB scores compared to conventional management structures.

RESEARCH METHODOLOGY

Research Design

A cross-sectional survey design was utilized to collect data at a specific point in time from a sample of healthcare professionals across various healthcare institutions (Rizaie *et al.*, 2023).

Sampling Technique

A stratified random sampling method was employed to ensure that the sample accurately represents the various tiers and sectors within the healthcare delivery system in Tamil Nadu. The target population was initially segmented into strata based on relevant institutional characteristics, such as the category of healthcare facility (public, private, and non-government hospitals). Following stratification, healthcare personnel were randomly selected from each stratum.

Population and Sample

The target population encompasses healthcare professionals, including physicians, nurses, and allied health professionals employed in various healthcare institutions across Kanyakumari district, Tamil Nadu. The required sample size was determined using Cochran's sample size formula to achieve a statistically valid result with a 95% confidence level and a 5% margin of error. Out of 258 health professionals contacted, 224 questionnaires were completed (86.8.0% response rate). After the exclusion of incomplete questionnaires, a final sample of 210 participants was included in the analysis. Informed consent from the participants was also obtained prior to data collection.

Data Collection

Data were collected through a structured questionnaire featuring closed-ended and Likert-scale items during June – July 2026. The questionnaire was administered digitally via encrypted email and web-based survey platforms, ensuring high response rates while respecting the shift routines of health professionals. Participants were assured of complete anonymity and confidentiality to minimize common method bias in the sampling and their apprehension. The questionnaire was pretested to remove any ambiguity and vague terms. The questionnaire consists of three primary sections:

1. Socio-demographic profile: This section collected personal and job profile information, including age, gender, specialty, professional experience, and current position.
2. Antecedent Vectors: This section aims to evaluate organizational practices across five dimensions: employee empowerment, leadership style, job design, communication practices, and reward/recognition systems. These measures are adapted from validated organizational scales, including Liao & Chuang (2004) and Macey & Schneider (2008), tailored to clinical workflows.
3. Organizational Citizenship Behavior: This section evaluates extra-role behaviors across five core dimensions: altruism, conscientiousness, sportsmanship, civic virtue, and courtesy, utilizing the validated scale established by Organ (1988).

Data Analysis

The data were analyzed using SPSS, employing various statistical procedures to gain insights into the factors influencing OCB in healthcare organizations. The profiles of participants were analyzed through percentages. Cronbach's alpha reliability coefficients were evaluated for all multi-item scales utilized in the study to ensure internal consistency. All constructs exceeded the standard acceptable threshold of 0.70: OCB Scale = 0.87, Employee Empowerment Scale = 0.82, Perceived Leadership Style Scale = 0.81, Job Design Index = 0.78, Internal Communication Practices Scale = 0.86, and High-Performance Workplace Systems Index = 0.84. Pearson correlation test was used to assess the relationship between employee empowerment and OCB dimensions. The link between leadership style and OCB engagement was explored through a chi-square test, and the impact

of job design on OCB was analyzed through multiple regression analysis. Factor analysis was applied to identify key communication practices affecting OCB, and a two-way ANOVA was used to examine the influence of recognition and reward systems. Additionally, a t-test was conducted to analyze the impact of high-performance workplace management on OCB.

RESULTS AND FINDINGS

Demographic Profile

Table 1 presents the socio-demographic profile of the study participants. The participants were predominantly male (60.9%) and composed of individuals aged 31–40 years (43.8%), followed by those aged 20–30 years (33.8%). Over half of them held a bachelor's degree (50.5%), while 30% possessed a nursing diploma and 19.5% held a master's degree or specialized medical qualification. Almost 41% of participants had 4–6 years of healthcare experience. Most participants were employed in private hospitals (46.2%), with 37.1% represented by government hospitals. While nursing and clinical support staff formed the largest occupational subgroup (39%), with medical/surgical staff constituting 28.6%.

Table 1

Socio-demographic profile of the participants (N=210).

Socio-demographic variables	Category	Frequency (n)	Percentage (%)
Gender	Male	128	60.9
	Female	82	39.1
Age group	20–30 years	71	33.8
	31–40 years	92	43.8
	41–50 years	32	15.2
	51+ years	15	7.1
	Technical / nursing diploma	63	30.0
Educational Qualification	Bachelor's degree (MBBS/BSc/BBA)	106	50.5
	Master's Degree / MD / Specialist	41	19.5
	1–3 years	40	19.0
Experience in Healthcare	4–6 years	87	41.4
	7–10 years	56	26.6
	10+ years	27	12.9
	Public / Government Hospital	78	37.1
Type of Organization	Private Multi-Specialty Hospital	97	46.2
	Charitable / Non-Profit Facility	35	16.6
	Clinical & Nursing Support	82	39.0
Nature of Work	Medical & Surgical Staff	60	28.6
	Allied Health/Administration	45	21.4
	Diagnostic/ & Laboratory Services	23	10.9

Empowerment vs. OCB Dimensions (H₁)

To test H₁, Pearson correlation coefficients were calculated between employee empowerment and the five OCB dimensions. The results confirm statistically significant positive correlations across all five dimensions. Employee empowerment correlates most strongly with Conscientiousness ($r = 0.71$, $p < 0.001$) and Civic Virtue ($r = 0.68$, $p < 0.001$). Entrusting healthcare staff with decision-making autonomy encourages greater thoroughness in clinical tasks and increased participation in organizational governance. Therefore, H₁ is fully supported

Table 2*Results of Correlation Analysis*

OCB Dimension	Pearson Correlation (r)	p-value	Statistical Significance
Altruism	0.63	0.000	Highly Significant ($p < 0.001$)
Conscientiousness	0.71	0.000	Highly Significant ($p < 0.001$)
Sportsmanship	0.52	0.003	Significant ($p < 0.05$)
Civic Virtue	0.68	0.000	Highly Significant ($p < 0.001$)
Courtesy	0.61	0.001	Highly Significant ($p < 0.001$)

Leadership Style and OCB Engagement Tiers

To evaluate H₂, a Chi-Square Test of Independence was conducted to assess the association between perceived leadership styles and categorized OCB engagement levels (high, moderate, low).

Table 3*Leadership style and OCB engagement*

Leadership Style	High OCB Engagement	Moderate OCB Engagement	Low OCB Engagement	Category Total
Transformational	54	29	5	88
Transactional	25	53	16	94
Laissez-faire	5	13	10	28
Total	84	95	31	210

Chi-Square Test Statistic= 31.82, Degrees of Freedom = 4, p-value = 0.0004.

The chi-square test confirms a statistically significant relationship between leadership style and employee OCB engagement ($\chi^2 = 31.82$, $p = 0.000$). Transformational leadership produced the highest rate of high OCB engagement (61.36 within its category), whereas Transactional Leadership resulted primarily in moderate OCB engagement (56.3%). Laissez-faire leadership yielded the highest proportion of low OCB responses (35.71%). H₂ is fully supported.

Multiple Regression Analysis: Job Design as an OCB Predictor (H₃)

Multiple Linear Regression was executed to test H₃, evaluating how structural job design characteristics (autonomy, task identity, feedback) predict overall employee OCB scores.

Table 4*Results of multiple regression analysis*

Model Parameter	Unstandardized β	Std. Error	Standardized β	t-value	p-value
(Intercept)	1.084	0.088	—	12.318	< 0.001
Job Design Index	0.486	0.054	0.642	8.958	< 0.001

Model Summary: $R = 0.642$, $R^2 = 0.412$, Adjusted $R^2 = 0.409$, $F = 80.24$, $p < 0.001$.

The regression analysis demonstrates that structural job design accounts for 41.2% of the variance in total OCB ($R^2 = 0.412$, $F = 80.24$, $p < 0.001$). The positive regression slope ($\beta = 0.486$, $t = 8.958$, $p < 0.001$) indicates that optimizing job autonomy, task feedback, and role scope significantly increases voluntary citizenship behaviors among healthcare professionals. H₃ is supported.

Factor Analysis of Internal Communication Practices (H₄)

Exploratory Factor Analysis (EFA) with Varimax rotation was performed to structure the underlying communication variables driving OCB (H₄).

Table 5*Results of exploratory factor analysis*

Communication Dimension	Specific Survey Indicator	Factor Loading
Team Communication	Open information sharing across multidisciplinary clinical teams	0.86
	Structured inter-departmental shift handovers	0.81
Supervisory feedback	Regular, constructive feedback from department supervisors	0.82
	Timely administrative responses to clinical staff queries	0.77
Institutional transparency	Clear communication regarding institutional policy changes	0.79
	Visible executive leadership communication during crises	0.74
Dispute resolution	Established procedures for addressing workplace conflicts	0.75

The factor structure illustrates that Peer and team communication (loading 0.86) and Supervisory feedback (loading 0.82) are the strongest operational drivers of voluntary extra-role behaviors within hospital settings. Clear inter-departmental communication minimizes operational ambiguity, encouraging healthcare personnel to support peers voluntarily (H_4 supported).

Two-Way ANOVA: Recognition and Reward Systems (H_5)

A two-way analysis of variance (ANOVA) assessed the main and interaction effects of structured recognition systems and formal reward systems on employee OCB scores.

Table 6*Results of Two-Way ANOVA*

Source of Variation	Sum of Squares (SS)	df	Mean Square (MS)	F-Value	p-Value	Significance Level
Recognition System	108.2	1	108.20	8.12	0.005	Significant ($p < 0.01$)
Reward System	99.3	1	99.30	7.45	0.007	Significant ($p < 0.01$)
Tenure (Control Variable)	62.1	2	31.05	2.33	0.099	Not Significant ($p > 0.05$)
Interaction (Rec times Rew)	42.5	1	42.50	3.19	0.075	Marginally Significant
Error / Residual	272.7	205	1.33	—	—	—
Total Model	584.8	210	—	—	—	—

The results reveal that while both recognition systems ($F=8.12$, $p=0.005$) and reward systems ($F=7.45$, $p=0.007$) exercise strong, independent effects on employee organizational citizenship behavior, the marginally significant interaction indicates a nuanced boundary condition regarding how these two motivational levers interact. The marginal trend ($p < 0.075$) suggests that formal rewards and non-monetary recognition may act as partial substitutes rather than strong multipliers. Specifically, the presence of a robust recognition program can partially buffer against the motivational deficit of lower formal financial rewards, and vice versa. Thus, by combining equitable financial/career rewards with regular non-monetary recognition maximizes employee willingness to engage in OCB. H_5 is supported.

Independent Samples T-Test: High-Performance Workplace Systems (H_6)

To evaluate H_6 , an independent-samples t-test compared OCB mean scores between institutions operating under high-performance workplace systems (HPWPs) and those using traditional management approaches.

Table 7*Results of Independent Samples T-Test*

Operational Framework	N	Mean OCB Score (μ)	Standard Deviation (σ)	t-Statistic	Degrees of Freedom (df)	p-Value
High-Performance Workplace Systems (HPWP)	118	4.34	0.39	7.140	208	< 0.001
Standard Management Systems	92	3.48	0.52	—	—	—

The independent samples t-test confirms a statistically significant difference between management systems ($t = 7.140$, $df = 208$, $p < 0.001$). Healthcare professionals in HPWP environments scored significantly higher on the OCB scale (4.34) than those under standard management structures (3.48). H_6 is fully supported.

DISCUSSION

The findings of this study provide strong quantitative support, demonstrating that organizational antecedent vectors directly influence OCB among healthcare professionals. All six hypotheses (H_1 to H_6) were fully supported. The demographic distribution reflects the current structure of the local healthcare ecosystem. Most of the respondents were male, while the 31-40 age group formed the largest group, indicating a major chunk of the health workforce encompassed mid-career clinicians and administrators. Over half of the respondents held a bachelor's degree. Workplace experience was concentrated on the 4-6-year range, providing a sample with sufficient institutional familiarity to accurately evaluate organizational practices in the current scenario. The mix of participants from private, government, and non-profit hospitals ensures that the observed relationships between management practices and OCB transcend specific operational models.

The Pearson correlation analysis confirmed that employee empowerment shares a strong, positive relationship across all five OCB dimensions. Empowerment exhibited the highest correlations with conscientiousness and civic Virtue. These results suggest that when clinical and administrative staff are granted autonomy over operational decisions, they reciprocate by exhibiting greater meticulousness in patient care and active participation in hospital governance. The chi-square test of independence demonstrated that leadership style dictates OCB engagement tiers, with transformational leadership producing the highest rate of OCB engagement. Further, inspiring, vision-driven leadership motivates healthcare workers to transcend formal job descriptions. Transactional leadership resulted primarily in moderate OCB engagement, confirming that compliance-based leadership secures basic performance but rarely sparks discretionary extra-role effort. In contrast, Laissez-faire leadership yielded the highest proportion of Low OCB responses, proving that leadership absence degrades contextual performance. These findings build upon corroborating evidence that transformational leaders serve as key catalysts for extra-role behaviors (Sun *et al.*, 2025).

Multiple linear regression established that job design characteristics such as autonomy, task identity, and feedback explain 41.2% of the total variance in employee OCB. The standardized regression coefficient indicates that structuring clinical roles to maximize task significance and feedback directly drives discretionary contribution. This finding validates the findings of earlier studies within high-stress healthcare environments (Kalargyrou *et al.*, 2023). Exploratory factor analysis extracted four key communication dimensions. Peer & team communication (factor loading = 0.86) and supervisory feedback (factor loading = 0.82) emerged as the dominant drivers. Clear inter-departmental shift and transparent supervisory channels lessen operational haziness in emergency and routine healthcare settings, enabling professionals to extend help (altruism) and prevent interpersonal friction (courtesy).

The two-way ANOVA confirmed significant main effects for both structured recognition and formal reward systems on OCB scores. While career and financial incentives establish structural equity, non-monetary recognition validates psychological

value. Combining both mechanisms maximizes healthcare professionals' willingness to display sportsmanship and conscientiousness (Alshami *et al.*, 2023). Experience in the current job showed no significant main effect, demonstrating that reward structures drive OCB regardless of professionals' seniority. The independent-samples t-test revealed a stark, statistically significant difference in OCB scores between operational management frameworks. Organizations implementing bundled HPWPs, participatory decision-making, selective staffing, and comprehensive training achieve a higher mean OCB score compared to those under traditional management systems. Integrated management systems create a workplace environment where discretionary extra-role behaviors become the cultural norm (Ahmic & Cosic *et al.*, 2025).

The study also showed that hospital leadership development should prioritize transformational competencies over purely transactional oversight, training nurse managers and department heads to inspire vision and offer individualized support. Granting the mid-level professionals' moderate autonomy over shift management and immediate patient-care decisions directly elevates conscientiousness and operational agility. Moreover, healthcare organizations must pair equitable baseline compensation with recognition programs to sustain sportsmanship and altruism in high-burnout units. Finally, transitioning from traditional HR administration to integrated HPWPs optimizes staff engagement, driving system resilience and patient satisfaction across public and private sectors.

CONCLUSION

This study provides empirical evidence on the organizational determinants of organizational citizenship behavior among healthcare professionals in Tamil Nadu state. The findings prove that voluntary extra-role behaviors are highly responsive to structural human resource practices, job autonomy, transformational leadership, and open communication. By strategically developing these organizational antecedents, healthcare facilities can strengthen clinical teamwork, improve service delivery standards, and build long-standing operational resilience.

STUDY LIMITATIONS

The study utilized a cross-sectional design, which limits the ability to establish a clear causal relationship between organizational antecedents and OCB over time. Relying on self-reported data from healthcare professionals may introduce reporting bias. Furthermore, data collection was restricted to hospitals within one state, which may limit the generalizability of the findings to different cultural or international healthcare settings. Finally, a larger sample size across more specialized clinical departments would increase statistical power.

FUTURE RESEARCH DIRECTIONS

Future research should employ longitudinal designs to track how dynamic shifts in leadership and job design influence OCB over time. Replicating this study across different geographic regions and healthcare systems will also help validate the broad applicability of these organizational antecedent models.

POLICY RECOMMENDATIONS

This study's findings emphasize that organizations should transition toward HPWP models featuring decentralized clinical decision-making, continuous professional training, and structured employee involvement schemes. To develop transformational leadership capabilities, organizations should conduct leadership training for healthcare professionals focused on inspirational motivation, intellectual stimulation, and individualized consideration. Finally, pairing objective performance rewards with active peer-nomination recognition programs would incentivize both task accomplishments and voluntary citizenship actions.

DECLARATIONS

Ethical Considerations: This study strictly adhered to the Declaration of Helsinki and relevant national and institutional ethical guidelines. Informed consent was obtained. All procedures performed in this study were in accordance with the ethical standards of the Helsinki Declaration.

Consent for Publication: Not Applicable.

Availability of Data and Material: Data for this study will be made available upon a request from the corresponding author.

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