

Building Service Quality through Organizational Commitment: The Mediating Role of Work Discipline

Membangun Mutu Pelayanan melalui Komitmen Organisasi: Peran Mediasi Disiplin Kerja

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ABSTRACT

Service quality is an essential aspect of healthcare delivery because it reflects a hospital's ability to meet patients' needs and expectations. Service quality problems may be influenced by internal organizational factors, including organizational commitment and employee work discipline. This study analysed the effect of organizational commitment on service quality and examined the role of work discipline as a mediator. A quantitative approach was employed, involving 330 employees of Hospital X, selected through purposive sampling. Data were collected through questionnaires using organizational commitment, work discipline, and service quality scales based on Allen and Meyer, Hasibuan, and Parasuraman et al., respectively. Data were analysed using structural equation modelling (SEM) with AMOS version 23.0 through confirmatory factor analysis (CFA) and goodness-of-fit index (GOFI) testing. The results showed that organizational commitment had a positive and significant effect on work discipline, work discipline had a positive and significant effect on service quality, and organizational commitment had a positive and significant effect on service quality. Furthermore, work discipline mediated the effect of organizational commitment on service quality. These findings indicate that organizational commitment and work discipline are important factors in supporting improvements in service quality. The implications of this study emphasize the need to strengthen organizational commitment and consistently implement work discipline as a strategy for human resource development and improving hospital service quality.

ABSTRAK

Mutu pelayanan merupakan aspek penting dalam pelayanan kesehatan karena berkaitan dengan kemampuan rumah sakit dalam memenuhi kebutuhan dan harapan pasien. Permasalahan mutu pelayanan dapat dipengaruhi oleh faktor internal organisasi, termasuk komitmen organisasi dan disiplin kerja karyawan. Penelitian ini bertujuan untuk menganalisis pengaruh komitmen organisasi terhadap mutu pelayanan serta menguji peran disiplin kerja sebagai mediator. Penelitian menggunakan pendekatan kuantitatif dengan melibatkan 330 karyawan Rumah Sakit X yang dipilih melalui teknik *purposive sampling*. Data dikumpulkan menggunakan kuesioner dengan skala komitmen organisasi, disiplin kerja, dan mutu pelayanan berdasarkan teori Allen dan Meyer, Hasibuan, serta Parasuraman et al. Analisis data dilakukan menggunakan *Structural Equation Modeling* (SEM) dengan AMOS versi 23.0 melalui *Confirmatory Factor Analysis* (CFA) dan pengujian *Goodness of Fit Index* (GOFI). Hasil penelitian menunjukkan bahwa komitmen organisasi berpengaruh positif dan signifikan terhadap disiplin kerja, disiplin kerja berpengaruh positif dan signifikan terhadap mutu pelayanan, serta komitmen organisasi berpengaruh positif dan signifikan terhadap mutu pelayanan. Selain itu, disiplin kerja terbukti memediasi pengaruh komitmen organisasi terhadap mutu pelayanan. Temuan ini menunjukkan bahwa komitmen organisasi dan disiplin kerja merupakan aspek penting dalam mendukung peningkatan mutu pelayanan. Implikasi penelitian menekankan perlunya penguatan komitmen organisasi dan penerapan disiplin kerja secara konsisten sebagai strategi pengembangan sumber daya manusia dan peningkatan mutu pelayanan rumah sakit.

Kata Kunci:

Mutu Pelayanan, Komitmen
Organisasi, Disiplin Kerja

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INTRODUCTION

Service quality determines the extent to which hospitals meet patients' needs, expectations, and rights to safe, appropriate, and high-quality care (Tarmizi, 2023). Donabedian (1988) assessed quality of care through structure, process, and outcomes, while Parasuraman et al. (1988) divided service quality perception into five dimensions: tangibles, reliability, responsiveness, assurance, and empathy. The Lancet Global Health Commission on high-quality health systems places competent care and positive user experience at the core of service delivery, especially in low- and middle-income countries (Kruk et al., 2018). In Indonesia, the Ministry of Health states that quality improvement is necessary to fulfill patients' rights, build a culture of quality in health facilities, and protect hospital human resources (Tarmizi, 2023).

Internal data from Hospital X also highlights this issue. Employee attendance records for August–October 2024 note 314 instances of tardiness (119 cases in August, 153 in September, and 42 in October), as well as two employees absent without explanation, indicating a problem with work discipline. Public assessments via Google Reviews as of September 14, 2024, also show an average of 3.5 out of a scale of 5 based on 158 reviews, suggesting room for improvement in service quality. These two initial indicators formed the empirical basis for selecting Hospital X as the research site.

Service quality depends on organizational factors and human resources. Mosadeghrad (2014), based on interviews with 222 healthcare stakeholders, found that provider, organizational, and health system factors influence quality and that managing employee processes is one avenue for improvement. Pratiwi et al. (2022) view hospital service quality as a reflection of the organisation's operational system. A study of inpatients at a hospital in North Sumatra showed that the dimensions of reliability, responsiveness, assurance, and empathy are significantly associated with patient satisfaction, whereas tangibles are not (Ginting et al., 2024). These findings draw attention to staff behaviour in serving patients.

Organizational commitment is a human resource factor related to quality. Meyer and Allen (1991) define it as a psychological state that describes the relationship between members and their organization and formulated its three components: affective commitment (emotional attachment), continuance (consideration of the cost of leaving the organization), and normative (a sense of obligation to stay). A meta-analysis by Meyer et al. (2002) showed that commitment, especially the affective component, is linked to work behaviors that are valuable to the organization. Among nurses, professional commitment predicts the quality of care as perceived by patients (Teng et al., 2009), and Chang et al. (2021) examined the relationship between the three components of professional commitment and five dimensions of service quality.

Commitment as an attitude needs to be manifested in work behavior, and work discipline is one form of this.

Hasibuan (2020) defines discipline as the awareness and willingness of employees to comply with organizational regulations and social norms, as reflected in punctuality, proper job performance, and adherence to rules. Hamali (2018) states that discipline maintains order and the smooth execution of tasks. In hospitals, procedures and service standards require consistency, making staff discipline a component of the service process that is evaluated within the framework of structure, process, and outcomes (Donabedian, 1988; Setyawati & Lestari, 2022). The flow proposed in this study is as follows: organizational commitment provides a psychological foundation, work discipline translates that foundation into behavior in carrying out tasks, and that behavior affects service quality. With this flow, work discipline has the potential to serve as a mediator.

Previous studies have examined some aspects of this pathway. Organizational commitment has a positive effect on work discipline among nursing staff (Nur et al., 2021), and similar relationships have been reported by Sarrafah et al. (2018) and Tarigan (2016). Work discipline has a positive effect on service quality in hospitals (Setyawati & Lestari, 2022), public service offices (Kasih & Wijaya, 2022), village offices (Patmasari et al., 2023), and community health centres (Kuspina, 2024), but was not significant among 41 nurses in a hospital in Pekanbaru (Mulyani et al., 2024). Commitment affects service quality at community health centres (Lestari, 2021), district offices (Supendi & Rahadian, 2021), insurance companies (Haris, 2017), and among nursing staff (Chang et al., 2021; Teng et al., 2009). For mediation, Sarrafah et al. (2018) positioned discipline as a mediator between compensation and organizational commitment on hospital employee performance; Nazaruddin et al. (2022) investigated service quality as an intervening variable between commitment and discipline with performance; and Fadilah and Setiani (2025) did not find work discipline to mediate between organizational commitment and land office employee performance.

The evidence reveals two gaps. First, findings regarding the effect of work discipline on service quality remain inconsistent (Kuspina, 2024; Mulyani et al., 2024). Second, previous studies have examined the direct relationship between variables or used employee performance as the outcome, and to the author's knowledge, there are few studies that position work discipline as a mediator between organizational commitment and service quality within a single structural equation model among hospital employees.

This study aims to analyze the influence of organizational commitment on service quality and to test the mediating role of work discipline among employees of Hospital X. Its hypotheses are as follows: (H1) organizational commitment has a positive effect on work discipline, (H2) work discipline has a positive effect on service quality, (H3) organizational commitment has a positive effect on service quality, and (H4) work discipline mediates the effect of organizational commitment on service quality. The novelty of this research lies in testing the behavioral mechanism linking commitment attitudes with service quality within a single

model. Theoretically, its results enrich studies in organizational psychology and human resource management in the health sector; practically, the findings can serve as a basis for hospital management to design human resource development to improve service quality.

RESEARCH METHODS

This study employed a quantitative method. The population in this study consisted of 385 employees at Hospital X, North Sumatra. The sampling technique used was purposive sampling, namely employees who were directly involved in patient care. The sample in this study comprised 330 employees, drawn from the population of 385 employees across nine divisions: general and HR (89), medical services (138), supporting services (79), specialist doctors (24), finance (15), directors/administration/personnel (14), marketing (9), general practitioners (9), and casemix (8).

This study measured three variables: organizational commitment, work discipline, and service quality, using Likert-scale questionnaires. The organizational commitment scale was adapted from Sulistiawan et al. (2020) based on Meyer and Allen's (1991) three-component model; of 24 items tested on 93 nurses at JIH Hospital Yogyakarta, 9 items met reliability requirements and are used in this study. The work discipline scale was developed by Afandi and Veritia (2024) based on eight discipline factors by Hasibuan (2020); all 16 items tested on 75 employees of PT Aditama Inovasi Asia were found valid and reliable. The service quality scale is from Manurung et al. (2022) and refers to the five dimensions of service quality by Parasuraman et al. (1988); all 36 items tested on 100 inpatients at RSIA Nabasa were found valid and reliable.

Data were analysed using structural equation modelling (SEM) through Analysis of Moment Structures (AMOS) version 23.0 in two stages: measurement model analysis with confirmatory factor analysis (CFA) and structural model analysis with model fit testing (goodness of fit). Hypotheses H1 through H3 were tested partially with the critical ratio (C.R.), and H4 was tested with the Sobel test (Sobel, 1982). The model fit criteria followed Ghazali and Fuad as well as Wijayanto (in Sarjono & Julianita, 2015) and are presented in Table 1.

Table 1. Cutoff Value Criteria for Standard GOF Testing

<i>Goodness Of Fit Index</i>	<i>Cut-Off Value</i>
χ^2 Chi-square ($p = 0,05$)	< Chi-square tabel
Sig. Probability	≥ 0.05
Df	> 0
CMIN/DF	≤ 2.00
GFI	≥ 0.90
AGFI	≥ 0.90
CFI	≥ 0.90
IFI	≥ 0.90
TLI atau NNFI	≥ 0.90
RMSEA	≤ 0.08

Convergent validity is accepted if the loading factor value is ≥ 0.5 (Hair et al. in Wijanto, 2008). Construct reliability is accepted if the construct reliability (CR) > 0.7 and variance extracted (VE) ≥ 0.5 (Hair et al. in Wijanto, 2008). A

measurement model is considered viable if at least four fit criteria are met (Sarjono & Julianita, 2015).

RESEARCH RESULTS

1. Respondent Characteristics

The respondents in this study consisted of 330 employees of Hospital X who worked directly in public/patient services. The demographic profile of the respondents, including gender, age, highest level of education attained, and length of service, is presented in Table 2.

Table 2. Respondent Characteristics (N = 330)

<i>Characteristics</i>	<i>Category</i>	<i>Frequency (n)</i>
Sex	Male	112
	Female	218
Age	< 25 Years old	45
	25 – 35 Years ol	185
	36 – 45 Years old	78
	> 45 Years old	22
Education Level	D3 / D4	142
	S1 / Profesi	176
	S2	12
Length of Service	< 2 Tahun	52
	2 – 5 Tahun	164
	6 – 10 Tahun	82
	> 10 Tahun	32

Most respondents were female (218 people, 66.1%), while male respondents numbered 112 (33.9%). This indicates that both medical and non-medical service personnel at Hospital X are predominantly women. Most respondents were in the productive age group of 25–35 years, totalling 185 people (56.1%), followed by the 36–45 year old range with 78 people (23.6%), those under 25 years old with 45 people (13.6%), and those over 45 years with 22 people (6.7%).

The most common educational background among respondents was S1/Profession, with 176 people (53.3%), followed by D3/D4 with 142 people (43.0%) and S2 with 12 people (3.6%). This indicates that most employees possess adequate higher education qualifications to support the hospital's operational duties.

Based on work experience, the most dominant group had a tenure of 2–5 years, totalling 164 people (49.7%), followed by tenures of 6–10 years (24.8%), less than 2 years (15.8%), and more than 10 years (9.7%). This indicates that most employees have a good understanding of and adapt to the hospital's organizational climate.

2. Descriptive Test

Table 3. Descriptive Statistics of Research Variables

Variable	n	Min	Max	Mean	SD	Category
Organizational Commitment (X)	7	14	35	27.45	4.12	High
Work Discipline (M)	15	32	75	58.2	7.85	High
Service Partnership (Y)	29	60	145	112.65	13.4	High

Based on Table 3, the results of the descriptive statistical overview for each variable are explained as follows: Organizational Commitment (X): The organizational commitment variable (measured with 7 valid items) has a mean value of 27.45 with a standard deviation of 4.12, from a theoretical/empirical range of 14 to 35. This value indicates that, overall, employees of Hospital X have a high level of organizational commitment. Work Discipline (M): The work discipline variable (measured with 15 valid items) yielded a mean value of 58.20 with a standard deviation of 7.85, from a range of 32 to 75. This result indicates that the employees' level of discipline falls within the high/good category. Service Quality (Y): The service quality variable (measured with 29 valid items) had a mean value of 112.65 with a standard deviation of 13.40, from a score range of 60 to 145. This shows that employees' perceptions of the quality of service provided are in the high/good category.

3. Assumption Test

Table 4. SEM Assumption Test Results

Types of Assumption Tests	Parameter	Results	Criteria	Note
Univariate Normality	Score c.r. Skewness & Kurtosis	-1.984 s.d. +2.152	$-2.58 \leq \text{c.r.} \leq +2.58$	Meeting Assumptions
Multivariate Normality	Score c.r. Multivariate Kurtosis	1.842	< 2.58	Meeting Assumptions
Multicollinearity & Singularity	Determinant of Sample Covariance Matrix Value	1.425×10^{-4}	> 0	Meeting Assumptions
Outlier Evaluation	Mahalanobis Distance (d^2)	$d^2 < \chi^2$ tabel	$p < 0.001$	Meeting Assumptions

Based on the details in Table 4, the fulfilment of SEM assumption tests is described as follows:

Data Normality Test:

- Univariate: The test results show that the critical ratio (c.r.) values for skewness and kurtosis of all indicators fall within the interval -1.984 to +2.152, which is within the 2.58 limit ($\alpha = 0.01$).

- Multivariate: The value of multivariate kurtosis yielded a c.r. of 1.842. This value is below the critical limit of 2.58 ($1.842 < 2.58$); therefore, we can conclude that the data are normally distributed both univariately and multivariately.

Multicollinearity and Singularity Tests:

- The assumption of no multicollinearity and singularity was assessed using the determinant of the sample covariance matrix. The AMOS output showed a determinant of 1.425×10^{-4} . This value is positive, indicating that the sample covariance matrix is not singular and that there is no perfect multicollinearity.

Outlier Data Evaluation (Outliers):

Outlier testing was conducted by comparing each respondent's Mahalanobis Distance (d^2) value to the Chi-Square (χ^2) table value at a significance level of $p < 0.001$. The evaluation results showed that none of the respondent data had a d^2 value exceeding the critical Chi-Square value, so all 330 data samples were valid and could proceed to the measurement model (CFA) and structural model analysis stages.

4. Analysis of the measurement model variables (measurement model) using Confirmatory Factor Analysis (CFA)

The measurement model analysis was conducted for each construct, and the results are presented in Table 5. Indicators with a loading factor below 0.5 were gradually removed until all remaining indicators met the convergent validity criteria. Ten out of the initial 61 indicators (two on organizational commitment, one on work discipline, and seven on service quality) did not meet these criteria. The organizational commitment construct achieved a fit in the fourth iteration, with all criteria fulfilled. The work discipline and service quality constructs had not yet met all fit criteria; their measurement was deemed adequate because some criteria were satisfied (Sarjono & Julianita, 2015). In the full model, construct reliability was 0.982 (> 0.7), and variance extracted was 0.659 (≥ 0.5), indicating that the construct and its dimensions have good reliability.

Table 5. Summary of Measurement Model Analysis (CFA)

Construct	Initial item	Valid item	Item dropped	Iterasi CFA	Measurement model fit
Organizational Commitment	9	7	2	4	All criteria are fulfilled
Work Discipline	16	15	1	3	Some criteria met
Service Partnership	36	29	7	2	Some criteria are fulfilled
Total	61	51	10	-	-

Note. Valid items: loading factor ≥ 0.5 in the final iteration.

5. Structural Model Analysis

The combined structural model was obtained after five iterations. Figure 1 presents the standardised estimates, and Figure 2 presents the unstandardised estimates.

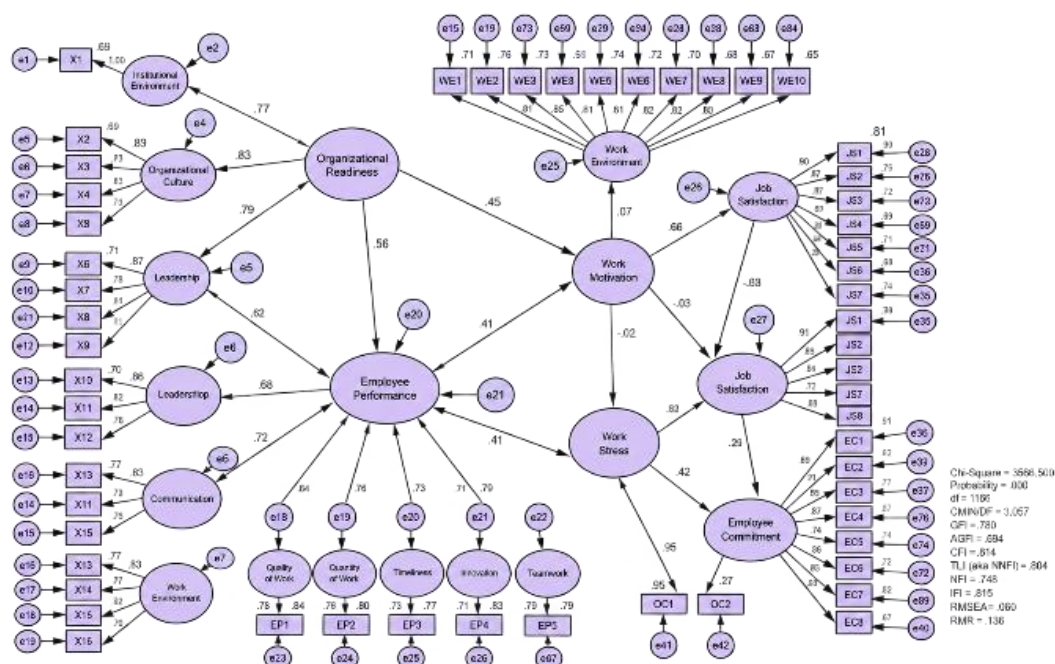


Figure 1. Full Model Diagram of the Combined Research Stages/Iteration_5_Fit (Standardized Estimate)

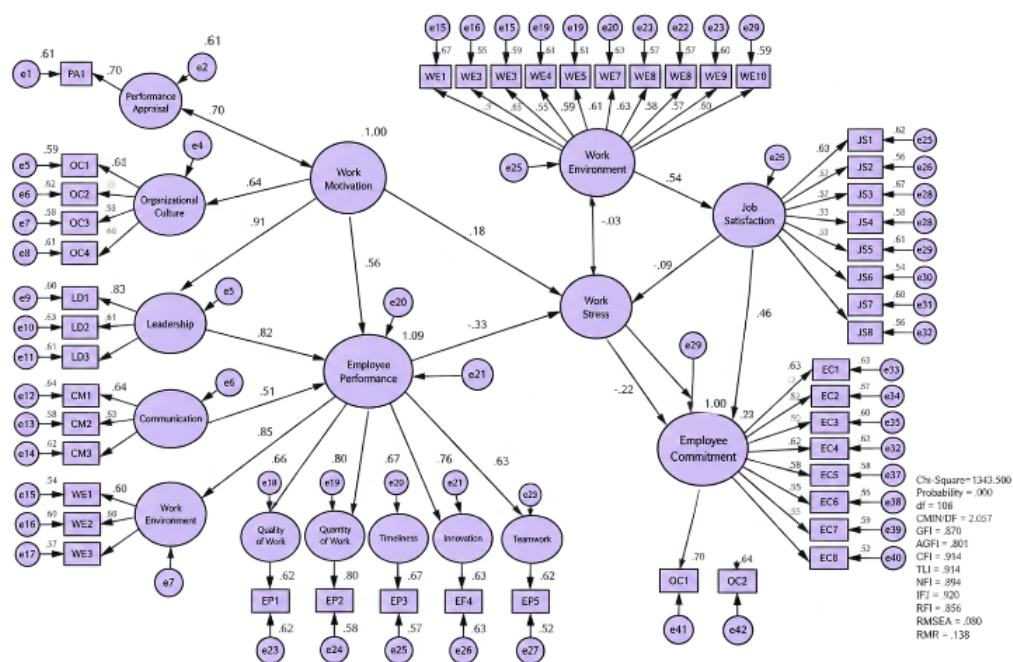


Figure 2. Full Model Diagram of the Combined Research Stages/Iteration_5_Fit (Un-standardized Estimate)

The results of Figures 1 and 2 were used to test the hypothesis. The full model fit indices from the AMOS output are presented in Table 6. Of the ten criteria in Table 1, only df and RMSEA were met, and RMSEA was exactly at the 0.08 threshold. The CMIN/DF value of 3.087 is still below the more lenient cutoff of 5 used by some researchers (Wheaton et al., 1977), but CFI, TLI, and IFI are below 0.90 and well below the 0.95 threshold recommended by Hu and Bentler (1999). Therefore, the overall model fit is considered marginal, and the following path estimates must be interpreted with caution.

Table 6. Full Structural Model Fit Indices

Indeks	Criteria	Results	Note
χ^2 (df = 1.165)	< 1.245,52	3.595.900	Not fulfilled
Probability	≥ 0.05	0.000	Not fulfilled
CMIN/DF	≤ 2.00	3.087	Not fulfilled
GFI	≥ 0.90	0.720	Not fulfilled
AGFI	≥ 0.90	0.694	Not fulfilled
CFI	≥ 0.90	0.814	Not fulfilled
IFI	≥ 0.90	0.815	Not fulfilled
TLI	≥ 0.90	0.804	Not fulfilled
RMSEA	≤ 0.08	0.080	Fulfilled

Note. The critical value of χ^2 at df = 1.165 and $\alpha = 0.05$ was 1,245.52.

a. Generated Regression Equation

Based on the results of the analysis of Standardized Regression Weights and residual (error of estimates) values in Squared Multiple Correlation, the regression equation for this study is

Structural Equation:

$$\text{Service Quality} = 0.155 * \text{Organizational Commitment} + 0.432 * \text{Work Discipline} + \text{error (1-0.279)} = 0.721$$

Substructural Equation:

$$\text{Work Discipline} = 0.512 * \text{Organizational Commitment} + \text{error (1-0.262)} = 0.738$$

b. Hypothesis Testing

Hypotheses H1 to H3 were tested using the critical ratio (C.R.) at a 5% significance level (critical value 1.96); the *** sign in the P column indicates significance at the 1% level. Mediation hypothesis (H4) was tested using the Sobel test (Sobel, 1982). Mediation is considered significant if the Sobel test probability is less than 0.05.

Direct Effect Analysis (C.R. test)

The results of the regression weight analysis of the combined model indicate that H1, H2, and H3 are supported (Table 7). Organizational commitment explains 26.2% of the variance in work discipline, and organizational commitment, together with work discipline, explains 27.9% of the variance in service quality.

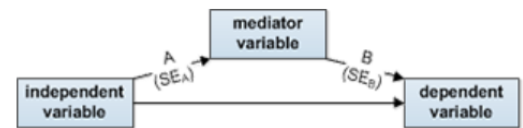
Table 7. Hypothesis Testing Results

H	Jalur	b	β	C.R.	P	Note
H1	Commitment → Discipline	0.596	0.512	8.249	***	Accepted
H2	Discipline → Quality	0.437	0.432	6.497	***	Accepted
H3	Commitment → Quality	0.183	0.155	2.485	0.013	Accepted
H4	Commitment → Discipline → Quality	-	0.221	Sobel = 5.123	0.000	Accepted

Note. b = unstandardised coefficient; β = standardised coefficient (in H4, standardised indirect effect); *** p < 0.001.

c. Sobel test (H4)

Rommy et al. (2022) refer to a variable as intervening when it also influences the relationship between the independent and dependent variables. The Sobel test was calculated using the Sobel Test Calculator for the Significance of Mediation program, with organizational commitment as the independent variable, work discipline as the mediator, and service quality as the dependent variable.



A: 0.596 ?

B: 0.437 ?

SE_A: 0.072 ?

SE_B: 0.067 ?

Calculate!

Sobel test statistic: 5.12313031

One-tailed probability: 0.00000015

Two-tailed probability: 0.00000030

Description:

Independent Variable: Organizational Commitment

Mediator Variable: Work Discipline

Dependent Variable: Service Quality

A: Direction of Influence of Independent Variable on Mediator Variable

B: Direction of Influence of Mediator Variable on Dependent Variable

SE: Standard Error

Figure 3. Sobel Test Calculation

Figure 3 presents the results of the Sobel test with the unstandardised coefficient for the path from organizational commitment to work discipline (A = 0.596; SE = 0.072) and from work discipline to service quality (B = 0.437; SE = 0.067). The Sobel statistic is 5.123 (> 1.96) with a two-tailed probability of 0.000 (< 0.05); thus, H4 is accepted. Because the direct effect of organizational commitment remained significant (H3), the mediation by work discipline was partial.

d. Analysis of Direct Effect and Indirect Effect

1) Direct Effect

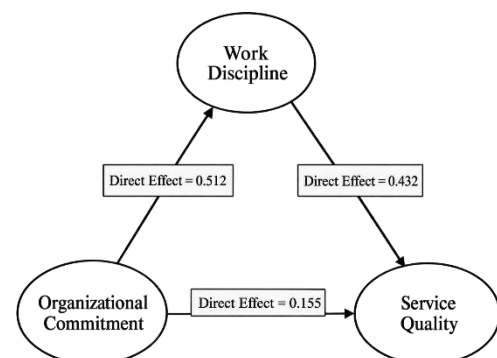


Figure 4. Direct Influence Coefficient Diagram

According to Figure 4, the direct effect of work discipline on service quality ($\beta = 0.432$) was greater than the direct effect of organizational commitment ($\beta = 0.155$).

2) Indirect Effect

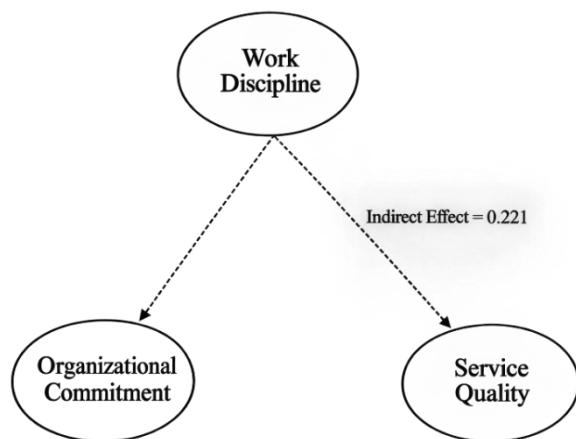


Figure 5. Indirect Effect

According to Figure 5, the indirect effect of organizational commitment on service quality through work discipline is 0.221 (0.512×0.432). The total effect of organizational commitment on service quality is 0.376 ($0.155 + 0.221$).

DISCUSSION

Organizational commitment has a positive and significant effect on work discipline and accounts for 26.2% of the variance in work discipline. Meyer and Allen (1991) distinguish affective, continuance, and normative commitment as three psychological states that bind employees to the organization, and a meta-analysis by Meyer et al. (2002) found that commitment, particularly affective commitment, is associated with work behaviors valuable to the organization. Kaswan (2019) stated that employees with high commitment tend to have good attendance and be loyal to organizational policies. A similar pattern is seen among nurses, whose organizational commitment explains 47.7% of the variance in work discipline (Nur et al., 2021), and positive relationships have also been reported by Sarrafah et al. (2018) and Tarigan (2016). The effect in this study was smaller than that of Nur et al. (2021). This difference may stem from the respondent composition, which included both medical and non-medical staff, and from the mix of commitment components, as continuance commitment leads to compliance based on consideration of the cost of leaving the organization (Meyer & Herscovitch, 2001). Hasibuan (2020) also noted that discipline is influenced by goals and abilities, leadership role modelling, compensation, fairness, supervision, sanctions, firmness, and interpersonal relationships; thus, commitment only explains part of discipline.

Work discipline has a positive and significant effect on service quality. Hasibuan (2020) views discipline as the willingness to comply with organizational rules and norms, and Hamali (2018) states that discipline maintains order and facilitates the smooth execution of tasks. In Donabedian's framework (1988), the quality of the care process depends on how staff carry out procedures, and timeliness as well as adherence to standards are included within this process. These findings are consistent with Setyawati and Lestari

(2022) in hospitals, Kasih and Wijaya (2022) and Patmasari et al. (2023) in public services, as well as Kuspina (2024) in community health centers. Edy Sutrisno in Marnisah (2020) also stated that discipline affects employee work productivity. Different results emerged among 41 nurses at a hospital in Pekanbaru, where discipline did not significantly affect service quality, while competence had a significant effect (Mulyani et al., 2024). The small sample size and the role of competence may explain this difference. That study did not include commitment, and this research does not measure competence; therefore, the relative weight of discipline versus competence cannot yet be assessed.

Organizational commitment also has a direct effect on service quality, with the smallest coefficient among the three pathways in this study. Muninjaya (2023), referencing Deming, Juran, and Joiner, positions leadership and staff commitment as key elements in developing healthcare service quality. Lestari (2021) reported the influence of management commitment on the quality of primary healthcare services, Supendi and Rahadian (2021) reported the effect of organizational commitment in district offices, and Haris (2017) reported similar findings in insurance companies. Among nursing staff, Teng et al. (2009) found that professional commitment predicted perceived quality of care ($\beta = 0.13$), particularly in the dimensions of responsiveness and empathy. Chang et al. (2021) examined the affective, continuance, and normative components of professional commitment on five dimensions of quality among 430 nurses across three measurement waves. The coefficient in this study ($\beta = 0.155$) approximates the findings of Teng et al. (2009), indicating that the direct effect of commitment on quality is small but consistent. Both Taiwanese studies investigated professional commitment; therefore, this comparison applies to the pattern of relationships and does not equate the constructs.

Sobel test results indicate that work discipline mediates the effect of organizational commitment on service quality. The indirect effect (0.221) is greater than the direct effect (0.155), and the direct effect remains significant; thus, the mediation is partial. Robbins and Judge (Atrizka et al. (2021) view commitment as employees' allegiance to the organisation and their involvement in achieving its goals. Hasibuan (2020) positions discipline as the key to an organisation's success in achieving its objectives, and Hamali (2018) states that discipline helps work proceed in an orderly manner. These three perspectives support the notion that a committed attitude impacts service when manifested through behaviour adhering to procedures. Sarrafah et al. (2018) place discipline as a mediator between compensation and organizational commitment toward employee performance in a maternal and child hospital, and Nazaruddin et al. (2022) examine commitment and discipline in relation to performance with service quality as an intervening variable. Contrasting findings are reported by Fadilah and Setiani (2025): in a study of 43 land office employees, work discipline did not mediate the relationship between organizational commitment and performance. The different outcomes (employee performance in that study, perceived service quality in this study) and differing organizational

contexts may explain this discrepancy. The Sobel statistic assumes a normal distribution of the indirect effect; therefore, the bootstrap analysis recommended by Preacher and Hayes (2008) should be used to re-examine this mediation.

These findings have important implications for hospital human resource management. Mosadeghrad (2014) concluded that employee and process management are among the pathways to improved service quality, and Kruk et al. (2018) identified workforce quantity and skills as the foundation of high-quality health systems. Within the constraints of a model with marginal fit, commitment development can be directed toward fostering employee attachment to the hospital's values and objectives, while discipline reinforcement can use the factors formulated by Hasibuan (2020): leadership role modeling, fairness, supervision, sanctions, assertiveness, and rewards. As the indirect effect of discipline is greater than the direct effect of commitment, programs linking commitment development with discipline enforcement have empirical grounds in these data.

This study has four limitations. First, the data were obtained from a single hospital using a cross-sectional design; thus, the results cannot be generalized, and causal direction cannot be determined. Second, all variables were measured through employee self-reports, including service quality, which was not assessed by patients. This study did not conduct statistical tests for common method bias, such as Harman's single-factor test or latent method factor (Podsakoff et al., 2003); thus, inflation of inter-variable relationships cannot be ruled out. Third, the overall model fit was marginal (Table 6), and ten indicators were dropped in the CFA; thus, path estimates should be interpreted with caution. Fourth, leadership, competence, job satisfaction, workload, and organizational support were not analyzed. Further research should involve more than one hospital, including quality assessments from patients (Teng et al., 2009), test mediation effects using bootstrap, and refine the model specification until fit criteria are met.

CONCLUSION

The results of this study are as follows: (1) organizational commitment has a positive and significant effect on work discipline; (2) work discipline has a positive and significant effect on service quality; (3) organizational commitment has a positive and significant effect on service quality; and (4) work discipline mediates the effect of organizational commitment on service quality with an indirect effect of 0.221. The marginal overall model fit and measurement of service quality based on employee perceptions require cautious interpretation.

For the management of Hospital X, these results support a human resource development program that combines strengthening commitment with the enforcement of work discipline in the hospital. For subsequent researchers, studies involving several hospitals or other public service institutions, with quality assessments from

patients, bootstrap-based mediation tests, and additional variables such as leadership, organizational support, and workload, will be required to test the strength of these findings.

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ETHICAL APPROVAL

This research received official permission from the Director of Hospital X through a research application letter submitted by the Master of Psychology Study Program at Medan Area University. Data collection took place from January 12–22, 2025, after receiving the director's approval. Participation was voluntary; participants received an explanation of the study's purpose, and data were analyzed and reported in aggregate without revealing participant identities.

STATEMENT OF INTEREST

The authors declare that there are no conflicts of interest in the research and writing of this article.

DATA TRANSPARENCY

Research data in the form of questionnaire scores and AMOS outputs are available from the corresponding author upon reasonable request, while maintaining the confidentiality of the participant and hospital identities.

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AI USAGE STATEMENT

During the revision stage, the authors used Paperpal to assist with the language editing. The authors checked all citations against their original sources and take full responsibility for the data, analyses, interpretations, and manuscript content.

AUTHOR CONTRIBUTIONS

H.R.S. contributed to the conceptualisation, data collection, analysis, and drafting of the initial manuscript. S.H. and Y.F.I. contributed to the supervision, methodology validation, and manuscript review.

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