UNIVERSITY OF CAPE COAST

THE RELATIONSHIP BETWEEN WORK-FAMILY CONFLICT AND ORGANIZATIONAL COMMITMENT AMONG THE MEDICAL PRACTITIONERS IN CAPE COAST

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2018

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BY

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Dissertation submitted to the Department of Managements of the School of Business, College of Humanities and Legal Studies, University of Cape Coast, in Partial Fulfillment of the Requirements for the Award of Master of Business Administration degree in General Management

NOVEMBER 2018

ABSTRACT

This study examined the relationship of Work family conflict on organizational commitment among medical practitioners in Cape coast metropolis. The purpose of the study is to examine the relationship between WFC and affective commitment, WFC and continuance commitment and WFC and normative commitment. There were one predictor variable, work family conflict and one criterion variable, organizational commitment. Both variables were measured through questionnaires and interviews. WFC was measured through WFC scale and organizational commitment was measured through organizational commitment scale. These questionnaires were distributed among the respondents. Both qualitative and quantitative research methods were used. Out of 271 questionnaires distributed 250 questionnaires were retrieved with response rate of 92.2%. The results were processed with SPSS v 20 and analyzed with ANOVA. The results of the study revealed that WFC existed among the respondents, however it had a positive relationship with Affective commitment, Continuance commitment and Normative commitment among medical practitioners. It is recommended that hospital managements should consider the factors leading to work family conflicts and reduce those factors by introducing work -life balance policies such as flexible working hours.

KEY WORDS

Organizational commitment

Affective commitment

Continuance commitment

Normative commitment

Work Family conflict

Medical practitioners

ACKNOWLEDGEMENTS

I am very grateful to my supervisor Dr. (Mrs.) Abigail Opoku Mensah, its being a long and stressful journey but her contribution and guidance in diverse ways made this research work a success.

I want to thank all medical doctors of Cape Coast metropolis who made time out of their busy schedule to participate in this study.

Finally, I wish to thank my children; Nana Kweku, Maame Efua and Ewura Aba for their support and understanding.

DEDICATION

To the Keegifts

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WFC	-	Work Family Conflict
FWC	-	Family to work conflict
WIF	-	Work interfering with Family
FIW	-	Family interfering with Work
AC	-	Affective Commitment
CC	-	Continuance Commitment
NC	-	Normative commitment
WHO	-	World Health Organization
UCC	-	University of Cape Coast
SPSS	-	Statistical Package for the Social Sciences
ANOVA	-	Analysis of Variance
TBC	-	Time based conflict
SBC	-	Strain based conflict
BBC	-	Behavioural based conflict

CHAPTER ONE

INTRODUCTION

Modern life has many problems within different dimensions. As we grow and age in life, there are milestone that we have to achieve at a particular point in time. Example of these milestone are work life and family life which are most important domains in every adult lives. Some individual may decide to achieve either work life or family life, but some may decide to achieve both which may lead to work family conflict (Magnus & Viswesvaran, 2005). This chapter focuses on the background of the study, statement of the problem, purpose of the study, hypothesis and significance of the study.

Background to the Study

Work-family Conflict (WFC) is an important factor to be considered when one wants to achieve both work-life balance and organizational commitment. This is because these two roles are often in conflict as individuals struggle to play roles as a member of a household and an organization. They have to meet the obligations of both roles with limited time and energy. The limitation of time and resources can cause increased stress, tiredness, weariness, performance loss, decrease of work satisfaction and organizational commitment, (Magnus & Viswesvaran, 2005).

WFC is an important issue of today business world because it has to be entangled by high level of positive waves which is of great importance in achieving the personal and professional objectives effectively and efficiently (Head, 2010). Also, the permeability between family and work scopes has produced WFC to be one of the psychosocial risks receiving more attention during the past years (Ammons & Kelly, 2015). WFC is an important factor to

be considered when one wants to achieve work-life balance (Yili &Zhou, 2017). This is because simultaneously performing the role of an employee, parent, and spouse may result in stress and conflict (Koekemoer & Mostert, 2010).

WFC can be defined as "a form of inter role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect, (Grandey, Cordeiro & Crouter, 2005). Individuals experience more conflict between work and personal life as they continue to pursue the quality of life that they need (Casper, Harris, Taylor-Bianco & Wayne, 2011). WFC has grown because of increases in women's labor force participation and rising expectations for fathers' involvement in daily care of children, (Lapierre et al., 2017).

It is noted that as one experience growth, regardless of gender, work-family conflicts decline (Cinamon, Weisel & Tzuk, 2007). This is attributed to the fact that those who are work-oriented make accommodations that meet their need for challenges while allowing for career enrichment and those who are family-oriented will seek accommodations to minimize conflicts with family requirements (Cinamon Weisel & Tzuk, 2007). WFC is suggested by many scholars to occur when employees bring problems and stress from the job to their homes that negatively affect their family's quality of life while FWC occurs when family responsibilities interfere with the employee's work-related duties which can lead interferes with work outcomes like organizational commitment, job satisfaction, and turnover (Afzal & Farooqi, 2014; Aslam, Shumaili, Azhar & Sadaqat, 2013; Dartey-Baah, 2015; Hsu, 2011).

WFC can have an overwhelming impact on the functioning and well-being of individuals, families, organizations, and societies (Hassan, Dollard, & Winefield 2010). It increases family conflict rates, decreases family satisfaction and organizational commitment, (Wayne, Butts, Casper, & Allen 2017). Organizational commitment is seen as the degree to which an employee is loyal to their organization, (Hassan, Dollard, & Winefield 2010). It is characterized by acceptance of the organization's values; willingness to do exert effort on behalf of the organization; and desire to remain an employee of the organization. In terms of organizational outcomes, studies have found support for a strong positive relationship between work-family conflict and job burnout (Ahmad, 2010); and a strong negative relationship between work-family conflict, job satisfaction and organizational commitment (Hassan, Dollard, & Winefield 2010). To minimize WFC and increase employees' commitment to the organization in times of productivity and performance, there should be work-life balance.

Today, work-life balance has become an increasingly pervasive concern to both employers and employees of most organizations (Lapierre et al., 2017). It primarily deals with an employee's ability to properly prioritize between work and his or her lifestyle, social life, health and family (French, Dumani, Allen & Shockley, 2017). Scholars and advocates concerned about work-family conflict have argued for changing the social structure of workplaces, that is mutually reinforcing practices, interactions, expectations, policies, and reward systems that reflect and reinforce the ideal worker schema (Albiston 2010).

Healthcare has been identified as a very expensive service in most countries (Lanseng & Andreassen, 2007). Nowadays, hospitals are confronting

great competition and scarce resources more than ever before. They are also severely challenged by the external and internal environment to achieve their goals effectively and efficiently. Doctors play an important role in determining the quality and cost of healthcare. It is argued that they have the potential to be part of solutions to key problems in health care systems (Boehman, 2006). Doctors' work life balance and organizational commitment are found to influence the hospital performance and productivity (Adebola, 2005). Therefore, if work family conflict set in, their hospital may not achieve their goals.

In view of this, it is important to identify WFC and its effect on organizational commitment in order to ensure healthy practices among medical doctors on work-family balance. For example, flexible working hours, casual leave entitlement, alternative work arrangements, children school fund, child care centers, benefits in lieu of family care responsibilities and compensation packages. Ross (2010) stated that management needs to assess the causes for improper work-family balance and lay down strategies to overcome those hurdles. For managers, it is found that there is a significant relationship between WFC and the managerial efficiency (Popoola, 2008), and that WFC has become a significant factor in predicting organizational commitment as one of the important factors that influence work attitudes.

As the saying goes – "Health is Wealth". Health is considered as the most important phenomenon in today's world which determines the wealth of the country at large, (Kim, 2015). The input of doctors to help Ghana to achieve sustainable development goal 3, which is to provide good health and well-being for all cannot be overlooked. However, there is shortage of medical

doctors due to attractive salary packages offered by other countries, better career opportunity and standards of living, (Haynes & Fryer, 2000). This has contributed to the high patient to doctor ratio, 10,450 to 1, (Owusu, 2017) in Ghana, As a consequence, the currently available medical practitioners at both the public and private hospitals have to resort into filling the vacuum with long hours of work and little break in between. They are sometimes obliged to work for 24 hours, 48 hours and once in a while considerably more. For married medical practitioners, the additional work burden may create stress due to the conflicts experienced with their spouse, and other family members which may be extended to their patients, peers, and even supervisors at worst (Haynes & Fryer). In view of these mentioned roles and responsibilities of doctors, managing WFC and putting measures for organizational commitment for doctors are paramount importance for every country.

Statement of the Problem

The medical practitioners like any other profession, are prone to the effect of WFC. In Ghana, because of the high doctor to patient ratio, 1 to 10, 450 ratio (Owusu, 2017), instead of the recommended ratio 1 to 1320 by World health organization and 1 to 5000 by Commonwealth (Owusu, 2017), it is expected that working in the hospitals and meeting the demands of these patients can be stressful for both doctors and hospital management. There are rich literature in WFC, predominantly its relationship with organizational commitment, Casper, Harris, Taylor-Bianco, A. & Wayne 2011; Nart & Batur 2014 . This current study is of no exception to the literature reviewed. It will intend focusing on the relationship of WFC on Affective commitment, Continuance commitment and Normative commitment.

While it is obvious that WFC is bound to be a common phenomenon among medical officers, unfortunately few studies have been carried out among individuals in this particular profession, Aziz, 2004; Ajiboye, 2008; Akintayo, 2010; Arizi, Dibaji & Sadeqi, 2011; Aslam, Shumaila, Azhar, & Sadaqat, 2011, Babalola, Oladipo, & Chovwen 2015. From the literature reviewed, majority of studies done among medical practitioners on WFC were not related to organizational commitment, Adam, Gyorffy & Susanszky 2018, Ahmad, Che &Jamal, 2018 and Ahmad, 2010. The final gap in the literature review is the involvement of medical practitioners. In the study of the relationship of WFC and Organizational commitment. It is against this backdrop that the researcher intends to examine the relationship between work-family conflicts and organizational commitment among medical practitioners in Cape Coast as the case study.

Purpose of the Study

The general objective of the study is to examine the effects of work-family conflicts on organizational commitment of medical practitioners in hospitals in Cape Coast metropolis. To achieve the purpose of this study, the following specific objectives were formulated;

i. To examine the relationship between WFC and affective commitment of medical practitioners in Cape coast metropolis

ii. To examine the relationship between WFC and continuance commitment of medical practitioners in Cape coast metropolis.

iii. To examine the relationship between WFC and normative commitment among medical practitioners in Cape coast metropolis

Research Hypothesis

With respect to the previous researches reviewed, the following hypothesis were formulated for testing.

i. H_1: There is a negative relationship between WFC and affective commitment of medical practitioners.

ii. H_1: There is a negative relationship between WFC and continuance commitment of medical practitioners.

iii. H_1: There is a negative relationship between WFC and normative commitment of medical practitioners.

Significance of the Study

Historically, work life balance issues have been considered personal issues (Emslie & Hunt, 2009), and employers have just responded to their employees' needs by providing additional benefits such as onsite childcare service and paid maternity leave in the workplace. However, with environmental shifts and value changes of employees, employees' desire for work life balance has increased and employers have begun to offer more active support of their employees' work life balance (Thornthwaite, 2004).

This study seeks to find out if work family conflict exists among medical practitioners and if it has any influence on organizational commitment. The study will therefore help enlighten management of various hospitals about the various factors that result in the WFC so that they can put measures in place to either prevent it or minimize its occurrence. The study will also bring out specifically the extent to which medical practitioners are committed to their work and the hospital as a whole. This study will go a long way to illustrate the effect of WFC among medical practitioners on

organizational commitment. Furthermore, hospitals can utilize the findings as a guideline to develop family-friendly policies. The findings play an important role in terms of hospitals and open new perspectives and understandings. These findings can guide health institutions in terms of working on advancing their management policies to retain staff and enhance organizational commitment.

Delimitation

This study was confined to WFC bidirectional nature of work family conflict and Organizational commitment such as Affective commitment, Continuance commitment and Normative commitment

Limitations of the Study

The collection of the data was through the use of questionnaires and interview because of the mixed nature of the research. The questionnaire was limited to the responses of the respondents. During the data collection some of the respondents felt they were busy and thus reluctant in responding to the instrument. Also due to their busy schedule and different working hours, collecting data was really difficult and time consuming. Additionally, respondents felt that their family issues were too personal to share and also their commitment level to their organization will be brought to book so the responses elicit could not be a truth reflection of their organizational commitment. Nevertheless, the respondents were assured of anonymity and confidentiality of their responses. The final limitation might be the sample features which comprise of all doctors in both private and public hospitals. The working condition in these two set of hospital may differ, affecting their WFC and organizational commitment.

Organization of the Study

The study was organized in five Chapters. Chapter One dealt with the introduction which explained the background of the study, problem statement, the objectives of the study which have been divided into specific objectives and general objective. It also talked about the research questions, the significance of the study and delimitation and limitations of the study, as well as the organization of the study; Chapter Two dealt with the literature review. In the review of literature, discussions on issues of work-family conflict were looked. Chapter Three dealt with the research methodologies used for the study. It includes the research design for the study, sampling, among others. Chapter Four dealt with results and discussions. Chapter Five looked at the summary, conclusions and recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews literature on the issues the study sought to investigate. Literature is reviewed on the Theoretical Framework which include the Social identity theory, time dependent commitment theory, role related and self-concept theory, then conceptual explanationing which includes review on Work-family Conflict (WFC) and Organizational commitment. The conceptual framework concludes this chapter.

Theoretical Review

The literature that investigates the relationship between organizational commitment and WFC/FWC covers different models and theoretical perspectives (Akintayo, 2010; Hassan, Dollard and Winefred, 2010). A lot of theories have been proposed in relation to WFC and organizational commitment. Some of the theories are discussed below.

Social Identity Theory (1)

One way of understanding organizational commitment is to understand how attitudes and behaviours are shaped by the psychological relationship between the employee and the organization (Rhoades & Eisenberger, 2002). This relationship has been conceptualized by the social identification process (Haslam, Knippenberg, Platow and Ellemers, 2003; Hogg & Terry, 2000; Riketta, 2005). The main concept behind social identity approach is the notion of group membership; in other words, individual`s sense of who they are based on their group. Therefore, understanding organizational commitment brings the necessity of involving social identity theory as it might help to

understand the underlying reasons of certain aspects of organizational commitment. The importance of the theory to this study is that as an employee identifies him/herself with an organization, even though they may experience WFC, they may still be committed to their organization.

Role Related Theories (2)

Role means a set of behavior-regulatory expectations linked to a given position in the society (Fabian, 2007). Individuals may fulfill several roles at the same time. Research focusing on the consequences of this phenomenon has come out with two variants: the theory of scarcity and the theory of enhancement. According to the scarcity theory of roles, the resources (i.e., time, energy) of the individual is limited and multiple roles inevitably reduce the resources available to meet all role demands, thus leading to role conflict, which subsequently may cause strain and may increase the prevalence of psychological and physical morbidities (Haar & Bardoel, 2008).

The more roles an individual undertakes, the more probable it is that fulfilling one role will damage the other which leads to exhaustion of resources. It can be deduced that, as one takes up

The theory of Enhancement states that taking up multiples roles may even result in positive consequence (Sieber, 1974). He suggested that when one fulfill multiple roles simultaneously, the advantageous influence may outnumber strain caused by role accumulation the significance of this theory to the underlying study is that, the more role (parent, wife, worker etc) an individual undertake, the more probable it is that fulfilling one role will damage the other, thus work will interfere with family, family will interfere with work and organizational commitment.

Overview of Work-Family Conflict (WFC)

Work and family are the main systems in the life of each person forming a unique aspect of human behavior and each person should balance between both aspects. Work-family conflict is said to have occurred when the requirements of each of two domains (work) with the demands of other domain (family) are incompatible and this conflict can affect family life quality and work life quality (Adams, Gyorffy & Susanszky 2008). The field of work–family conflict has gained a lot of attention in many organizations worldwide, and employees are experiencing a lot of work-related and family-related conflict due to changing workplace dynamics.

Howard, (2008) defined Work-Family Conflict (WFC) as a type of inter-role conflict where both work and family issues exert pressures on an individual, creating a conflict where compliance with some set of pressures (family matters) increases the difficulty of complying with the other set of pressures (work matters). It has also been suggested by Parasuraman & Collins (2001) as a consequence of inconsistent demands between roles in work and in family. In other words, work-family conflict is likely to occur when expectation in one role does not meet the requirement in another role, preventing efficient performance in the other role. Thus, these conflicts arise when one gives more time to work and less time to family and vice versa. For example if one comes home late after work and due to more pressure of work unable to pay attention to his family then it will create the conflict, (Maslach, Schaufeli & Leiter, 2001).

WFC implies a bidirectional relationship conflict occurring in both domains as a major issue affecting both employees and employers, (Hamid &

Amin, 2014). The work-family conflict facet was defined as a form of inter-role conflict occurring as a result of general demands and strain created by the job interfering with one's ability to perform family related responsibilities and it leads into mental pressure and the reduction of personal and organizational health criteria (Arizi, Dibaji & Sadeqi, 2011). A lot of studies have proved that work-family conflict can be bidirectional in nature (Allen et al., 2013; Beutell, 2010; Kinnunen, Feldt, Mauno & Rantanen, 2010; Rathi & Barath, 2013; Qiu & Fan, 2015;). Thus, work-to-family conflict (W-FC) or work interfering with family (WIF) which implies that issues at the workplace interfering the family issues and the family-to-work conflict representing (F-WC) or family interfering with work (FIW) also implying that issues at home clashing with work.

The sustainable conflict between work and family is related with some issues as job burnout, family and work strains, physical symptoms of disease, depression, alcohol abuse, bad relation of child-parent, negative behaviors of the children, the reduction of job satisfaction and increase of job leave and job absence (Lambert, Hogan, Camp & Yentura 2006). There are three types of WFC; time based conflict, strain based conflict and behavior based conflict (Greenhaus & Beutell 1985).

Time-Based Conflict

Time-Based Conflict refers to the time that is reduced to perform another role due to the one role that has been accomplished or time pressure to meet the demand of one role while struggling to meet the demand of the other role, (Lanseng & Andreassen, 2007). It may occur when time devoted to performing one role makes it difficult to participate in another. Generally, time

spent on one activity cannot be devoted to activities within another role. A study by Kim, (2014) suggested that long working hours has direct influence on work-family conflict by increasing stress, tiredness and inefficient work by employees. It is also evidenced when time pressures of one role prevent an employee from being able to allot time to meet the demands of another role.

Strain-Based Conflict

The second form of family-work conflict is the strain as the result of occupational and family strains. Strain-based conflict occurs when pressure or strain from one role affects how a person performs in another role. These stimuli in job and family roles create physical and mental pressures such as stress, anxiety, depression and aggression. It makes meeting the demands of another role difficult. It has been suggested that strain exists when engaging in one role intrudes and interferes with participating in another role, (Lanseng & Andreassen, 2007). According to Pleck, Staines and Lang, (2000), irritability dimension exists when the strain in one role gives impact to the performance in another role. The forms of strain include anxiety, tension, fatigue, irritability, depression, low energy or apathy.

Behaviour-Based Conflict

Behavior-based conflict occurs when specific behaviors required in one role are incompatible with behavioral expectation in another role, (Lanseng & Andreassen, 2007). That is, it occurs when one's role can hinder one's performance in another role. For example, high pressure environment in workplace will lead to inappropriate behaviours at home. It is possible that it is expected of a male executive manager to be bold in his duties but the family

members have different expectations from him and he is faced with different behavior expectations.

In this kind of conflict, special models of behavior in a definite role are incompatible with the expectations of the behavior in another role. It is possible that in job role, some behaviors are required of a person that are incompatible with the behavioral expectations in family role. When he/she cannot follow the behavioral expectations despite the behavior change, he is faced with behavior-based conflict (Mesmer, Magnus, Jessica & Viswesvaran, 2005). Work to family conflict affects the work life and family to work conflict affects the family life. Work life is a comprehensive construct including job health of a person, when a person work experiences are with the reward without strain and other negative outcomes (Burke, 2004).

The family life is the concept including the family health of a person, when his roles as father/mother and spouse are with reward without strain and other negative outcomes (Burke). Life satisfaction is arising from a person satisfaction of having a good. Maher et al. (2013) found that daily physical activity was positively related to overall satisfaction with life.

Factors Influencing Work Family Conflict

Three notable factors have been stated to influence WFC. This implies that if these factors are addressed, there will be work life balance thereby reducing WFC. The factors are the level of spouse support, parental demand and family involvement in taking care of the home.

Spouse Support

Spousal support is the help, advice, understanding, and the like that spouses provide for one another (Aycan & Eskin, 2005). There are two forms

of spousal support: emotional and instrumental support (Adams, 2001). Emotional support includes emphatic understanding and listening, affirmation of affection, advice, and genuine concern for the welfare of the partner. Instrumental support is tangible help from the partner in household chores and childcare (Aycan & Eskin). Findings have indicated that support from family members which includes spouses is an important variable affecting work-family conflict, (Gordon & Whelan, 2004). Also, study by Peltzer, Mashego and Mabeba, (2003) found that lack of spouse support contributed to stress for medical officers. There is empirical evidence that work and family support alleviates employees' work interference with family and family interference with work. Social support outside of work, such as that provided by spouses, may have a positive impact on work-family balance by reducing work-family conflict, (Ford, Heinen & Langamer, 2007).

Parental Demand

The various role demands imposed by the family domain has put pressure on an individual and affect one's work. Child rearing responsibilities will intrude into parents' working life and inhibit them from functioning in their jobs effectively (Anderson, Coffey & Byerly, 2002). Aryee, (1992) study showed that job–parent conflict reduced the quality of work. Also, parental demand was found to be related to work interference with family and family interference with work (Frone, Russel & Copper, 1997). Parental demand is the higher level of interference of family with work and vice versa (Anderson, Coffey & Byerly). From the above literature, it can be predicted that parental demand is positively related with work-family conflict.

Family Involvement

Family involvement as defined is the degree to which individuals are identified psychologically with their family roles, the relative importance of the family to individuals' self-image and self-concept, and the individuals' commitment to their family, (Jayaweera, 2005). Brough & Kelling (2002), reported that family support was significantly and negatively associated with conflicts in the work–family interface. Ford, Heinen and Langamer (2007), also found that family support alleviated WFC.

The concept of Organizational Commitment

Organizational commitment was defined by Boehman, (2006) as "psychological state that binds the individual to the organization and make them very much committed with their work. According to Dick (2011), Organizational commitment is an attitudinal or emotive dimension of work motivation, manifesting its form in members' behaviour. Recently, the concept of organizational commitment is major focus of administrative research. It is one of the issues of attitude that is defined as mental and intellectual relation to some issues and by improving attitude in an issue, the commitment increase is possible.

Understanding commitment process is useful for the organizational and society because it leads into the innovation of the employees, high stability in the institution and competition in the institution and the society can use high productivity of the organizational and better quality of the products. The organizational commitment has close relation with job satisfaction of the employees and from the second half of the 20th century "Motivation, job satisfaction and organizational commitment" are considered from interest

variables for organizational commitment understanding. The results of the study by Saatchi, Qasemi and Namazie, (2008). Showed that organizational commitment is related with many occupational behaviors of the employees and organizational commitment has serious effects on organization performance.

The organizational commitment is an attitude about loyalty to an organization and a continuous process that by participation of people in organizational decisions, the success of the organization is accomplished, (Abili & Nastizayi, 2009).

Types of Organizational Commitment

Organizational commitment has been classified into the following three categories by Greenberg, (2005) as; Affective commitment, Continuance commitment and Normative commitment

Affective Commitment

It is defined as the employee's positive emotional attachment and identification of the employees with the organization that is an individual's orientation towards the organization in terms of loyalty, identification and involvement (Robbins, Judge, Odendaal & Roodt, 2010). Employees who are emotionally dedicated usually remain with the organization because they see their employment as harmonious with the goals and values of the organization (Ferreira, Basson & Coetzee, 2010) Thus, the employee strongly identifies the goals and objectives of the organization and he desires to remain part of organization throughout his career. To ensure this, the goals of the organization and those of the individuals must increasingly congruent. Affective commitment can be measured by the acceptance of organizational

value and the willingness of an individual to stay in the organization. Individual with high affective commitment will act and behave at the organization's best interest, (Canipe, 2006).

Continuance Commitment

Continuance commitment describes investment that an employee makes towards an organization that is the material benefits gained from being with the organization (Akintayo, 2010). It also takes place when the investments such as service, career and additional benefits of an employee are quite high. The longer individuals remain in their organization, the more they have to lose (Ferreira, Basson, & Coetzee, 2010), but an employee with continuance commitment feels that it would be costly to leave the organization and therefore build a desire to continue working for the organization (Akintayo, 2010). Continuance commitment occurs when the gains or losses that an individual would have in case of continuing or leaving the organization are important to him. Therefore, the individual stays in the organization even if he does not want to do so. A person continues his works in the organization as he needs the benefits of the organization.

Normative Commitment

It is a type of commitment where an employee feels that it is obligatory i.e. 'due to norms or pressures from others', for him to continue working for the particular organization (Greenberg, 2005). Akintayo (2010) argues that WFC negatively correlates with affective and normative commitment. He found that committed employees are more likely to remain with the organization and strive towards the organization's mission, goals, and objectives than others. This type of commitment is arising from a person

values in the organization, he believes that he is indebted to the workplace and no organization can be successful unless the members of the organization can be committed and attempt to attain the aims (Nasr, 2011).

These three approaches of commitment are not mutually exclusive and it is possible for an employee to develop one or any combination of the three aspects of commitment Laka-Mathebula (2004). Morgan (2012) is of the view that, from an attachment perspective, it can be said that affective commitment reflects the strength of the relationship, continuance commitment reflects duration and normative commitment reflects responsibility.

Empirical Review

Work family conflict is indeed an issue that can affect almost all aspects of people's live, (Appelbaum, Berg & Kalleberg, 2000). It has adverse concerns for both employees and organizations (Hamid & Amin, 2014). WFC when managed appropriately can lead to significant consequences, for instance job satisfaction, family satisfaction, family performance, work performance, marital satisfaction and organizational commitment (Greenhaus & Allen, 2011).

Relationship between WFC and Organizational Commitment

WFC causes an imbalance between work and family life and these conflicts interferes with outcomes of organization such as job dissatisfaction, job burnout, and organizational commitments. Also, WFC has been shown to be related negatively to work outcomes such as psychological distress and marital dissatisfaction, (Howard, Donofrio & Boles., 2004). People are more satisfied and show commitment toward their organization if organizations are supporting work family balance (Burke, 2000). Work-family conflict reduces

employees' job satisfaction which again reduces job performance of an employee and hence reduction in organizational commitment. (Abbass & Nadeem, 2009). WFC is negatively associated with our emotional response to work and people who have less work family conflict enjoy their life in family as well as in work (Zhao, Qu & Ghiselli, 2011).

Zohaib, Kamran, Atif and Samar (2014) explored the Effect of Work Life Conflict on Job Satisfaction of Doctors of Pakistan. Their study results indicated that the relationship between work life conflict and job satisfaction is negatively related among doctors. The results were consistent with the finding of Namasivayam & Zhao, (2007) that both the dimensions of Work life conflict were negatively related with job satisfaction and consequently their commitment to the organization.

Adam, 2008 did a study on Work-Family Conflict among Female and Male Physicians in Hungary and found out that even though female than male physicians reported family-to-work conflict, almost all physicians (99%) reported some degree of work-family conflict. Female physicians reported significantly more strain-based work-family conflict compared to men whereas male physicians experienced significantly more time-based work-family conflict than women. However, the prevalence of behaviour-based work-family conflict was relatively low among the physicians (around 10%). Thus, female physicians in Hungary often find themselves compelled to fulfil a number of roles (mother, spouse, doctor) at home and at work to the highest standards concurrently.

Researches done so far on WFC and organizational commitment have shown mixed responses. Some studies reported negative relationship between

WFC and Organizational commitment; others showed positive relationship whiles few suggested both positive and negative relationships to the various component of organizational commitment. In a study that explored the effects of work and family lives of the employees on the degree of organizational commitment, it was found out that the satisfaction in marriage and the social support offered by the spouses have a positive effect on the degree of organizational commitment (Zin, 2006). Sakthivel and Jayakrishnan (2010) revealed that organizational commitment is influenced through work-life balance in nursing profession. The results also showed that work to family interference is at higher level but family to work interference is at lower level in nursing profession.

Rehman and Waheed (2012), studied among faculty members in Pakistani Universities. This study examined the impact of work-family conflict on commitment to organization in public and private universities of Pakistan. Result suggested negative impact of work-family conflict on organizational commitment. There were no significant differences of work-family conflict between men and women or public and private university faculty members and the interactions were also insignificant. Bashir and Ramay (2008), stated substantial positive association among work-life policies, career opportunities and organizational commitment in information technology professionals which means that organizational policies with more family friendly environment leads toward organizational commitment and career development.

Akintayo (2010) studied the role of WFC toward commitment of industrial employees in Nigeria. From this study negative relationship between

commitment and WF interference was concluded. Organizational commitment decreased by increasing work-family conflict. Substantial difference was also revealed for men industrial workers and women industrial workers as well as for married and single status workers. Babalola, Oladipo and Chovwen (2015) also studied the influence of organizational factors and work-family conflict on organizational commitment among working parents. The data for the study was drawn from employees of health, banking, armed forces and educational sectors in the city of Ibadan, Oyo State, Nigeria. The result indicated that employees with high work-family conflict are more committed to their organizations.

Tabassum and Nazar (2014) studied the impact of work-life conflict on organizational commitment among faculty members of different universities in Pakistan. The results of the study revealed that there is negative and significant impact of work-life conflict on organizational commitment. It is also exposed that facets of work-life conflict also have negative and significant influence on organizational commitment. They recommended that for managers to enhance organizational commitment by their employees, they had to reduce work-life conflict and introducing work-life balance in their organizations.

Allen, Herst, Bruck and Sutton (2000) studied WFC in relation to the three-component model of commitment and found a negative relationship between WFC and affective form of commitment. Malik and Awan (2015) explored the relationship of work family conflicts with organizational commitment and organizational effectiveness among University Teachers and personnel of banking institutions. They found out there is highly significant

negative relationship between WFC and organizational commitment. With the individual assessment of WFC, there was negative significant relationship between WFC and affective organizational commitment as well as of work family conflicts and normative organizational commitment but there was a highly insignificant negative relationship of WFC and continuance commitment.

A study on Turkish primary teachers on the relation between work-family conflict, job stress, organizational commitment and job performance by Nart and Batur (2014) showed that work-family conflict has low degree effects on continuance and normative commitment, whereas no effect on affective commitment. Researchers' opinion about this finding is that teachers' efforts not to fall behind the yearly academic schedule that they are responsible to complete, and some central exams that their students need to pass which can possibly utilize as a measure to evaluate their teaching performances back up their personal commitment to the work, even if the existing work-family conflict that they face.

There have being other studies that have shown positive relationship in WFC to either one of the component of the Organizational commitment or to all of them. Others too showed no significant relationship. However, Efeog˘lu, (2006) who investigated the effects of work–family conflict of the employees in pharmaceutical industry on work stress, job satisfaction and organizational commitment could not find a statistically significant relationship between work–family conflict and organizational commitment. Streich, Casper and Salvaggio (2008) also found positive relationship between WFC and continuance commitment. Therefore, it is expected that employees who

experience high WFC and remain in their jobs, will perceive commitment as a need, not a desire or attachment (Casper, Buffardi, & Erdwins, 2002). The positive relationship between WFC and continuance commitment can be explained by self-concept theory by Thoits (1991).

Another study that also showed a positive relationship was done by Serap and Sonmez (2012). They investigated the relationship between WFC and organizational commitment among nurses and medical doctors at seven state universities and three medical faculties of Universities in Ankara. Analysis reviewed that the relationship between WFC and organizational commitment was weak and positive. Their results suggested that the more committed the doctors and nurses are to the hospital they work for, the more WFC they experience.

Mukanzi and Senaji (2014) researched and aimed at investigating the relationship between WFC and employee commitment in banking institution in Kenya. They found out that there was a positive relationship with Affective commitment, Continuance Commitment and Normative Commitment. Thus participants who reported greater WFC had higher levels with Affective commitment, Continuance commitment and Normative commitment. The study provided valuable insight into the WFC among employees with family responsibility in the banking institution. They concluded that their result not consistent with the findings of other study may be due to the cultural differences such us societal values and expectations linked to work and family activities between Kenya and other countries, which might have contributed to the difference.

Ahmad, Che and Jamal (2010) carried out a study on Family Issues and Work-Family Conflict among Medical Officers in Malaysian Public Hospitals. They found out that, only parental demand and not spouse support and family involvement was a significant predictor of the two dimensions of work-family conflict.

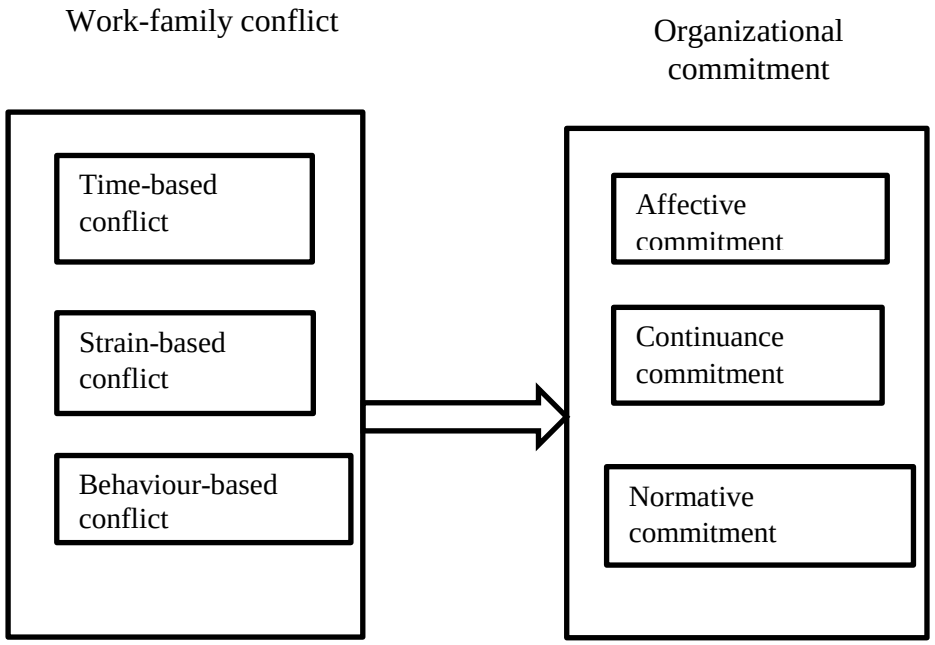
The previous studies investigated the relationship between work–family conflict and organizational commitment in different culture and organization structures. The majority of them indicated a generally negative relationship between organizational commitment and work–family conflict. In other words, the higher the work–family conflict, the lower the organizational commitment or as the work–family conflict decreases, organizational commitment increases. It is believed that studying this relationship by paying attention to the sub-dimensions of the organizational commitment will be beneficial for Ghana and health institutions.

The purpose of this study is to analyze the relationship between organizational commitment and work–family conflict among medical practitioners. The relationship between organizational commitment and work–family conflict will be tested in its three different sub-dimensions: affective commitment, continuance commitment and normative commitment. Not only will the analysis of this relationship contribute to the literature, but it will also shed light on whether taking preventive or remedial measures in work–family conflict will make a difference on the organizational commitment of medical practitioners.

Conceptual Framework

Based on the above literature reviewed, the conceptual framework has been developed.

Figure 1: Conceptual Framework



Source: Authors construct, 2018

The model illustrates what this study intends to explore and that is the relationship of work-family conflict that is using the multidimensional conflicts on organizational commitment. The arrow indicates the direct relationship that Time- based conflict, strain based conflict and behavioural based conflict has on organizational commitment. In this study, work-family conflict is studied as predictive variable (independent) and organizational commitment (affective commitment, continuance commitment and normative commitment) is studied as criterion variable (dependent).

Chapter Summary

This chapter review WFC, Organizational commitment, theories of WFC and Organizational commitment, and various studies done on WFC and

Organizational commitment**.** Based on these assumptions and literature, the current studies have mixed postulations. Some studies reported that Work-family conflict positively relates to Organizational commitment whiles others reported negative relationship. However, inasmuch as the review shows that some employees experience conflict at work and home, this research sought to examine how these claims are valid for this study area.

CHAPTER THREE

RESEARCH METHODS

Introduction

The general objective of the study is to examine the effects of work-family conflicts on organizational commitment of medical practitioners in hospitals in Cape Coast. This chapter focused on the methodology employed in gathering data. It included research designs, study area, population, sampling procedures and sample size, data collection instruments, data collection procedures and method of data processing and analysis.

Research Design

Research design depicts the outline and procedure that the researcher put down in the study, thus, the hypotheses and operational inferences to the final analyses of the data (Akubia, 2011). Both qualitative and quantitative research approaches were employed for the study. The quantitative method dealt with tables and figures which represented the findings from the data gathered. The use of the quantitative approach in the study also helped to analyze the data in terms of means and standard deviations as well as minimum and maximum values. Regression and correlation analyses were also carried out. The use of the qualitative approach in the study helped in probing further to find answers to some of the quantitative results. According to Creswell (2014), qualitative studies enable the researcher to delve into the experiences, concerns, and state of mind of participants within their natural settings in order to better understand them.

Study Area

This study was conducted at Cape Coast metropolis, the administrative capital of the Central Region of Ghana. The population of Cape Coast metropolis, according to the 2010 Population and housing census is 169,894 representing 7.7 % of the region's total population. It is believed that this figure has shot up. It has one teaching hospital, four hospitals, one polyclinic and three clinics manned by doctors. The total number of registered practicing medical doctors is 272 with majority of them (231) working at the teaching hospital (Cape coast regional health directorate, 2018).

The Cape Coast teaching hospital which was initially a regional hospital, is one of the five teaching hospitals in Ghana. It was inaugurated as a teaching hospital in 2008. This expanded its functions such as training of medical students and newly graduated medical doctors (house officers), grooming medical officers and also for postgraduate training. The second highest numbers of doctors (10) for this study were from the university of Cape coast hospital. Twenty three respondents were from Ghana health service. The hospitals under Ghana health service were, Cape coast metropolitan hospital, Ankaful leposarium hospital, Ankaful Psychiatric hospital and Ewim polyclinic. The private hospitals were DIS clinic, Sanford clinic and Baiden Ghartey hospital which had a total of 9 respondents

Population

The population in this study consisted of medical practitioners working full time in both private and public hospitals in Cape Coast metropolis. They comprised of House officers, Medical officers, Residents, Specialists and Consultants. The inclusion criteria were all doctors (thus irrespective of age,

gender, marital status and cadre) in both private and public hospital in Cape Coast metropolis. The hospitals used for the study were Cape Coast Teaching hospital, University of Cape coast hospital, Cape coast metropolitan hospital, Ankaful leposarium hospital, Ankaful Psychiatric hospital, Ewim polyclinic, DIS clinic, Sanford clinic and Baiden Ghartey hospital.

Sampling Procedure

Convenience sampling technique was employed to select the medical practitioners owing to their accessibility. It is a non-probability sampling that provides researcher option to choose target audience according to his/her choice and it increases the representativeness of the sample by subjective selection. Questionnaires were distributed to the medical practitioners. A sample size of two hundred and seventy one (271) medical practitioners were selected for the study. A follow up interview was later done using 20 doctors to provide justification to some of the quantitative results. These 20 doctors were randomly selected.

Validity and Reliability of the Instrument

In every research study, it is essential to test for the validity and reliability of the instrument used. The validity of an instrument guarantees that the variables used in the study are adequately measured. To make sure the questionnaire used is valid, the designed questionnaire was given to the supervisor for assessment. The remarks and recommendations of the supervisor was accurately noted and were immediately affected. Additionally, the reliability of a questionnaire guarantees its consistency with regards to the items measuring a specific variable. To make sure the questionnaire is reliable, Pre-testing was carried out using 22 medical practitioners at the Polyclinic of

Korle-Bu Teaching Hospital in Accra. The pretesting questionnaire for WFC and organizational commitment were eighteen and twenty four items respectively.

The Cronbach's alpha reliability method was utilized for the estimation of the overall questionnaire's reliability yielding Cronbach's alpha value for work-family conflict items as 0.86 and that of organizational commitment items was 0.790.

Table 1: Reliability Co-efficient of the Questionnaire's Sub-scales

Variables	Number of items	Co-efficient
Work to Family Conflict	18	0.86
Organizational commitment	24	0.79

The Cronbach's alpha value for both items are higher than the required value 0.70. According to Pallant (2010), a reliability co-efficient of 0.7 and above is enough. This means that internal components had acceptable correlations with one other. This means that the reliability criterion is met, and hence the analysis could be continued.

Data Collection Instruments

The instruments for data collection in this study were a well-structured questionnaire and interview. The questionnaire consisted of three sections. Sections A, B, and C. Section 'A' looked at the demographic characteristics of medical practitioners. Section 'B' focused on some of the work-family conflicts among medical practitioners, whiles Section 'C' centered on the commitment level of medical practitioners towards their organizations (hospitals). To evaluate work-family conflict, Work-Family Conflict Scale

developed by Carlson, Kamar & Williams (2000) was used. It was composed of 18 questions. Six items each measure different aspects of work interference with family, i.e., Time-based, Strain-based, and Behavior-based work-family conflicts. Each item is measured on a 5 point Likert type scale, with 1 representing strongly disagree and 5 representing strongly agree.

To evaluate Organization Commitment, Organization Commitment, Scale (OCS) developed by Allen and Meyer, (2000) was used. This scale measures organizational commitment and consists of 24 items. Eight items each measure Affective, Normative, and Continuance commitment and responses are made on 5-point Likert-type scale with 1 representing strongly disagree and 5 representing strongly agree. Each subscale composite score ranges from 8 to 24 with higher scores representing greater commitment. The scale has a fairly high reliability ($\alpha = 0.76$) and high construct and content validities (Allen & Meyer).

Ethical Considerations

An introductory letter seeking for ethical clearance was taken from the Department of management, School of Business, University of Cape Coast to the various hospitals. The letters were submitted to the chief executive officer, medical director and medical superintendent of the various hospitals and clinics to seek for ethical approval. Also, the participants were assured of confidentiality of the information being released and that their responses would not be linked to their identities.

Data Collection Procedures

The questionnaires were distributed after permission was granted. On the set dates of data collection, questionnaires were sent to the respondents. On each meeting, a brief introduction of the research was given to particular respondents. Medical practitioners who showed interest in participating in the research were given questionnaire to answer individually. Those who declined did not become part of the study. Both scales were self-explanatory, however if clarifications were needed they were given at that time or later on if the need arose. The scales were self-administered and completed at respondents' leisure. Some were collected at the time of meeting, while others later after the participant had completed them. Out of the 271 questionnaires that were distributed, 250 were distributed. The data collection lasted from May 2018 to August 2018. This was due to the busy schedules of the respondents.

Data Processing and Analysis

The data collected from the field was edited to check their completeness and accuracy of filling of responses. Data was analyzed using the Statistical Package for Social Sciences (SPSS) version 22 and Microsoft Excel. The data was represented on tables and then transformed into frequencies and percentages for ease of understanding. Thus, the data collected was subjected to descriptive statistical analysis by computing the Mean (Average) and Standard Deviation (SD) of each item. The researcher imposed minimum level of performance by a mean score of 3.50. Items which achieved a mean score lower than 3.50 in their ratings are said to be unsatisfactory. The decision rule was to reject an item whose mean fall below 3.60 since it used 5-point scale. Multiple regression analysis was carried out to

test the statistical relationship between work-family conflict and organizational commitment.

The content analysis of the qualitative data was done manually. The data was organized, reviewed and coded. The codes were combined into themes and relationships identified

Chapter Summary

The chapter begun with the recapping of what the study is about. It focused on the methodology employed in gathering data. It included research designs, study area, population, sampling procedures and sample size, data collection instruments, data collection procedures and method of data processing and analysis.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

The purpose of the study is to examine the relationship of WFC on organizational commitment of medical practitioners in hospitals in Cape Coast. This section looks at results of data gathered from the field. These are analyzed and discussed according to the research objectives. The section is presented in two forms. The descriptive statistical aspect and the further statistical part. The descriptive part looked at the demographic characteristics of medical practitioners while the further statistics focused on testing and validation of the hypotheses that were postulated to guide the study. The responses are presented below.

Demographic Characteristics of Respondents

The demographic characteristics of respondents were in relation to gender, age, marital status, cadre, type of organization, weekend duties, and night duties.

Table 2: Response rate

Questionnaires distributed	**Number**	**Percentages (%)**
Retrieved questionnaires	250	92.2
Unretrieved questionnaires	21	7.8
Total	**271**	**100**

Source: Fieldwork, Anane (2018)

Table 3: Gender of Respondents

Gender	Number of Respondents	Percentage(%)
Male	135	54.0
Female	115	46.0
Total	**250**	**100.0**

Source: Fieldwork, Anane (2018)

A total of 250 medical practitioners participated in the study. On their background and characteristics, it was observed that majority of the respondents (54%) were males and the remaining proportion (46%) were females. Although this asserts to the fact made in the Ghanaian occupational structure that the employment-to population ratio in the country is relatively higher in males than females (GSS, 2014), it can be said that the gap is gradually bridging up in the medical profession. This can be attributed to the much attention given to girl child education in Ghana lately.

Table 4: Age Range of Respondents

Gender	Number of Respondents	Percentage(%)
22-30	84	33.6
31-39	91	36.4
40-48	33	13.2
49-57	27	10.8
Above 57	15	6.0
Total	**250**	**100**

Source: Fieldwork, Anane (2018).

From Table 4, the highest number (36.4%) of participants were from the age range 31-39, followed by 33.6% of the age range 22-30.this can be

attributed to the fact that majority of the participants were house officers and medical officers.

Table 5: Marital status of respondents

Marital status	Frequency	Percentage(%)
Single	103	41.2
Married	128	51.2
Divorced	11	4.4
Separated	5	2.0
Widowed	3	1.2
Total	**250**	**100**

Source: Fieldwork, Anane (2018)

Table 5 shows that out of the 250 respondents, 128 respondents (51.2%) were married, 103 respondents (41.2%) were married. The number of respondents who were divorced, separated and widowed was 11 representing 4.4 percent, 5 respondents representing 2.0 percent and 3 respondents representing 1.2 percent respectively. This can be deduced that a greater number of respondents were married followed by the singles.

Table 6: Organization of respondents

Organization	Number of Respondents	Percentage(%)
Ghana Health Service	13	5.2
Teaching Hospital	218	87.2
UCC Hospital	10	4.0
Private Hospitals	9.0	3.6
Total	**250**	**100**

Source: Fieldwork, Anane (2018)

From table 6, majority of the respondents were from the Cape Coast teaching hospital. This may be because it is a training center for both graduate and postgraduate training for medical practitioners. The least respondents were from the private hospitals representing 3.6%.

Table 7: Cadre of Respondents

Cadre	Number of Respondents	Percentages
House officer	105	42.0
Medical officer	87	34.8
Residents	28	11.2
Specialist	26	10.4
Consultants	4	1.6
Total	**250**	**100**

Source: Fieldwork, Anane (2018)

Forty two percent and 34.8% of them are House Officers and \medical officers respectively. Also, 11.2%, 10.4% and 1.6% are Residents, Specialists and Consultants respectively.

Table 8: Weekend duties of Respondent

Do you work over the Weekend?	Number of Respondents	Percentage (%)
Yes	157	62.8
No	93	37.2
Total	**250**	**100**

Source: Fieldwork, Anane (2018)

Most (62.8%) of the respondents work on weekends whiles 37.2% do not work on weekends. Working on weekends may deprive some of participants from participating in family activities.

Table 9: Night duties of Respondents

Running of Night duties	Number of Respondents	Percentage(%)
Yes	157	62.8
No	93	37.2
Total	**250**	**250**

Source: Fieldwork, Anane (2018)

Table 10: Frequency of night duties of respondents

How Often Respondents Run Night Duties monthly	Number of respondents	Percentage(%)
1-2	26	10.4
3-4	64	25.6
5-6	20	8.0
7-8	23	9.2
9-10	16	6.4
Above	8	3.2
Total	**157**	**62.8**

Source: Fieldwork, Anane (2018)

One hundred and fifty seven respondents run night duties. When they were asked how often they run the night duties in a month, another 34.8% of them run night duties 3 to 4 times every month. This was followed by those who run night duties 1 to 2 times monthly with 18.8%. The least was those

who run night duties above 10 times in a month. This means that majority (34.8%) of the respondents run night duties 3 to 4 times in a month.

Table 11: Mean analysis of Age, Number of Children, Length of work and Hours of Work per Week

Variable	Sample	Mean	SD	Minimum	Maximum
Age	250	32.212	0.459	20.000	62.000
Children	250	0.9720	0.0796	0.0000	5.0000
Length of work	250	5.828	0.357	1.000	35.000
Hours of work in a Day	250	9.292	3.225	4.000	24.000

Source: Fieldwork Anane, 2018

Table 11 provides information on the mean analysis of ages, number of children, work experience and hours of work per week. The mean age of the medical practitioners in the sample was about 32 years, with a standard deviation of 0.459. The oldest person is 62 years whiles the youngest is 20 years. Also, the maximum number of children by medical practitioners was 5. There were medical practitioners who don't have children at all. The mean work experience of respondents was about 6 years whiles the highly experienced persons have worked at the various organizations for the past 35 years and the least work experience was those with only one year. The mean hour a medical practitioner in the sample works in a day was observed to be about 9 with a corresponding standard deviation of 3.225. The minimum hour a medical practitioner works is 4 and the maximum is 24 hours.

Further Analysis

To investigate the internal consistency of the questionnaire, Cronbach's alpha was used. The internal consistency of the work-family and

organizational commitment the research instruments was checked. The result is presented in the table below.

Predictors and Response Variables in the Study

The predictor in this study is work-family conflict which has three levels (time-based conflict, strain-based conflict and behavior-based conflict). Each of the three levels have six items each. The response variable in the study is organizational commitment of the medical practitioners. Organizational commitment also has three levels (Continuance, Affective and Normative commitment). As a rule of thumb in multiple regression analysis, the predictor variables are to be weakly correlated in order to prevent the problem of multicollinearity. However, the predictor variables are supposed to be highly correlated with the response variable. Table 12 provides information on the correlation between the dimensions of work-family conflict and that of the levels of organizational commitment.

Testing of Hypothesis

This study is to investigate whether the WFC components Time-based conflict (TBC), Strain-based conflict (SBC) and Behavior-based conflict (BBC) can predict organizational commitment. To study the prediction of organizational commitment by WFC, regression was applied and the results are shown in the Tables

Table 12: Mean analysis of Age, Number of Children, Length of work and Hours of Work per Week

Relationship Between WFC and Affective Commitment (AC) of Medical Practitioners

		TBC	SBC	BBC	AC
TBC	Pearson Correlation	1.000	0.627**	0.484**	0.173**
	P-value	*****	0.000	0.000	0.006
SBC	Pearson Correlation	0.627**	1.000	0.452**	0.033
	P-value	0.000	*****	0.000	0.598
BBC	Pearson Correlation	0.484**	0.452**	1.000	0.244**
	P-value	0.000	0.000	*****	0.000

Relationship Between WFC and Continuance Commitment (CC) of Medical Practitioners

		TBC	SBC	BBC	CC
TBC	Pearson Correlation	1.000	0.627**	0.484**	0.101
	P-value	*****	0.000	0.000	0.111
SBC	Pearson Correlation	0.627**	1.000	0.452**	0.049
	P-value	0.000	*****	0.000	0.443
BBC	Pearson Correlation	0.484**	0.452**	1.000	0.183**
	P-value	0.111	0.443	*****	0.004

Relationship Between WFC and Normative Commitment (NC) of Medical Practitioners

		TBC	SBC	BBC	NC
TBC	Pearson Correlation	1.000	0.627**	0.484**	0.094
	P-value	*****	0.000	.000	0.140
SBC	Pearson Correlation	0.627**	1.000	0.452**	0.108
	P-value	0.000	*****	0.000	0.088
BBC	Pearson Correlation	0.484**	0.452**	1.000	0.221**
	P-value	0.000	0.000	*****	0.000

Source: Fieldwork, Anane (2018) **significant at 0.05 (P<0.05)

On average, the variables have weak correlations among even though the relationships were all positive. That is to say, the correlations between the predictor variables are weak, and thus allowing for suitability of multiple regression analysis. According to Pallant, (2010), this condition suggests that the multicollinearity assumption is not violated and the regression results are not distorted.

Hypothesis One: There is a negative relationship between WFC Dimensions and affective commitment

Table 13: Relationship between Affective Commitment and WFC Components

Model	Sum of Squares	Degree of Freedom	Mean of Squares	F Statistics	P-Value
Regression	6.724	3	2.241	7.440	0.000
Residual	74.102	246	0.301		
Total	**80.826**	**249**			

Source: Fieldwork, Anane (2018)

Table 14: The Results of Simultaneous Regression of WFC on Affective Commitment

		Unstandardized coefficients					
Model Parameters		**B Coefficients**	**S.E**	**T-ratio**	**P-Value**	**R**	**R2**
Constant		2.159	0.175	12.342	*<0.000	0.288	0.083
	TBC	0.153	0.073	2.082	*<0.038		
WFC	SBC	- 0.150	0.065	-2.292	*<0.023		
	BBC	0.155	0.045	3.425	*<0.001		

Source: Fieldwork, (2018) *significant at 0.01 (P<0.05)

Based on simultaneous regression, it was observed that TBC predicts organizational commitment. Also, SBC negatively predicts organizational commitment and it has decreasing effect (P<0.023, B= - 0.150). BBC positively predicts organizational commitment. Based on the coefficient of determination (R-squared), 8.3% of the changes of affective commitment are explained by WFC while 91.7% is determined by other factors. The results show that WFC has positive effect on affective commitment. Therefore,

hypothesis one is rejected. Hence, there exists significant positive effect of WFC on affective commitment. The regression model is as follows:

Affective Commitment=2.159+0.153(TBC)-0.150(SBC)+0.155(BBC)

Hypothesis Two: There is a negative relationship Between WFC Dimensions and Continuance commitment

Table 15: Relationship between WFC and Continuance Commitment

Model	Sum of Squares	Degrees of Freedom	Mean of Squares	F Statistics	P-Value
regression	3.584	3	1.195	3.107	0.027
Residual	94.573	246	0.384		
Total	**98.156**	**249**			

Source: Fieldwork, Anane (2018)

Table 16: The Results of Simultaneous Regression of WFC on Continuance Commitment

		Unstandardized coefficients					
Predictive variables		**B Coefficients**	**S.E**	T-ratio	P-Value	R	R^2
Constant		2.221	0.198	11.242	*<0.000	0.191	0.037
	TBC	0.053	0.083	0.642	<0.522		
WFC	SBC	-0.063	-0.074	-0.853	<0.395		
	BBC	0.132	0.051	2.574	*<0.011		

Source: Fieldwork, Anane (2018).

Based on simultaneous regression, it was observed that TBC does not predict organizational commitment. Also, SBC negatively predicts organizational commitment. BBC positively predicts organizational commitment. Based on coefficient of determination (R-squared), 3.7% of the changes of affective commitment are explained by WFC while 96.3% of affective commitment is determined by other factors. The ANOVA results of

the effect of WFC on continuance commitment was found to be P=0.000<0.05, indicating statistical significance. The results show that WFC has positive significant effect on continuance commitment. Therefore, hypothesis two is rejected. Hence, there exists significant positive effect of WFC on continuance commitment. The regression model is as follows:

Continuance Commitment=2.221+0.053(TBC)-0.0630(SBC)+0.132(BBC)

Hypothesis Three: There is a negative relationship between WFC and Normative Commitment Dimensions

Table 17: Relationship between Normative Commitment and WFC Commitment

Model	Sum of Squares	Degree of Freedom	Mean of Squares	F Statistics	P-value
Regression	3.627	3	1.209	4.282	0.006
Residual	69.460	246	0.282		
Total	**73.088**	**249**			

Source: Fieldwork, Anane (2018)

Table 18: The Results of Simultaneous Regression of WFC on Normative Commitment

Model Parameters		Unstandardized Coefficients B Coefficients	S. E	T	P-value	R	R2
WFC	(Constant)	2.129	0.169	12.574	*<0.000	0.223	0.05
	TBC	-0.027	0.071	-0.381	<0.703		
	SBC	0.021	0.063	0.325	<0.745		
	BBC	0.135	0.044	3.088	*<0.002		

Source: Fieldwork, Anane (2018) *significant at 0.01 (P<0.05)

Based on simultaneous regression, it was observed that TBC does not significantly improve the prediction of normative commitment (P <0.703; B= -0.027). Also, SBC does not improve the prediction of organizational

commitment (P 0.745; B=0.021). Only BBC positively significantly improves the prediction of normative commitment and it has an increasing effect (P<0.002, B=0.135). Based on the coefficient of determination (R-squared), 5% of the changes of normative commitment are explained by WFC while 95% of affective commitment is determined by other factors. The ANOVA results of the effect of WFC on normative commitment was found to be P=0.006<0.01, indicating statistical significance. The results show that WFC has significant effect on normative commitment. Therefore, hypothesis three is rejected. Hence, there exists positive significant effect of WFC on normative commitment. The regression model is as follows:

Normative Commitment=2.129 0.027(TBC)+0.021(SBC)+0.135(BBC)

In this study, a quite weak but positive relationship was found between work–family conflict and organizational commitment. Also the result indicates that the higher the organizational commitment of the employees, the higher their work–family conflicts. Zin, (2006) asserts that the individuals who do not have any problems in their family lives and get the support of their spouses have more energy for their organizations and roles in their organizations because they have achieved balance in their emotional lives.

Based on the positive relationship, an interview was randomly conducted among 20 persons of the participants.

Response to Interview Question One

When asked if they intend to leave the hospital they are working now, 18 said no whiles 2 said yes. The reasons for those who said no are as follows:

a) Almost all of them (17 out of 18) said it was easy to get sponsorship for their post graduate training within 2 years. 'So there is no need to quit the job though the work interferes with family roles'.

b) 'It is better to stay in one hospital than to move from hospital to hospital.

c) 'It is easy to acquire surgical skills and professional growth if you stay in one hospital for a longer period of time.

d) 'For faster professional growth'

e) 'Challenges faced by this hospital are same for almost all other hospitals, so no need to leave but rather help to make it a better place to work'.

f) 'I am bonded to serve for some years after my postgraduate training, therefore I have to be loyal so that my junior colleagues will also get that opportunity'.

g) 'There are lots of opportunities in Cape Coast. One can easily get teaching appointment at University of Cape coast (UCC) or any of the Nurses training colleges whiles keeping to this profession and working in the same hospital '.

h) 'No transfer with the Cape Coast teaching hospital and UCC hospital, unless voluntarily'.

i) 'They want to have master's program at UCC because of proximity'.

j) 'Good schools in Cape coast for kids to attend'.

For those who said yes, these are their reasons

k) 'For better remuneration and allowance'.

l) 'Not able to meet family demands'.

m) ‘It is not a high paying job as perceived’.

Discussion of Results

The purpose of this study is to test the relationship between work–family conflict and organizational commitment. A lot of research studies have tested the relationship between work–family conflict and organizational commitment in different countries and occupational groups. The difference between these research groups and this study is that, this study investigates the relationship between three sub-dimensions of the organizational commitment (affective, continuance and normative) among medical practitioners in Ghana. The first finding of the study points out that WFC exists among medical doctors and the higher the Work–family conflict; the higher their affective commitment to the organization, hospital. This finding however, does not match with the findings of the studies by Malik and Awan (2015), Meyer, et. al., (2002) and Allen et al. (2000) who declared a significant negative relationship between work family conflicts and affective organizational. However it matches with other studies which showed positive relationship of WFC with affective commitment, Mukanzi and Senaji (2014). Affective commitment takes place when the individual associates his value and goals with those of a specific organization, and wants to continue his membership to the organization to achieve them (Capine, 2006).

The finding of this study can be attributed to various factors regarding the medical profession. Globally, every medical doctor is made to swear the Hippocratic Oath before they start practicing (Lasagna, 1964). This oath binds them to do no harm and saving life is always a priority irrespective of their personal or organizational challenges. Therefore, no matter how a doctor

experiences WFC, commitment to his duties become paramount. Also, per regulation of Ghana health services and almost all the other teaching hospitals in Ghana, it is required of every medical officers (MOs) to work with their institution for at least three years before they are allowed to pursue postgraduate program (Director General, Ghana health services, 2000). This is not the case with the Cape coast teaching hospital as management sponsor MOs who have even worked for less than a year. It was mentioned that all MOs who qualified to start their postgraduate program in 2017 were sponsored even though they had all worked less than 2 years. This gives a shorter professional path for MOs to become specialist. It may be on this premises that even though the respondents of this study experienced work family conflicts but their affective commitment was also high.

The second finding of our study shows that as the continuance commitment to the organization increases, the work–family conflict increases; and vice versa, as the continuance commitment decreases, so does the work–family conflict. This finding is contradictory to other studies by Adam, 2008 Boles et al, 2001, Namasivayam & Zhao, 2007. However, other previous studies showed a positive relationship between continuance commitment and work–family conflict (Mukanzi & Senaji 2014, Serap & Sonmez 2012). Streich et al., (2008) also found positive relationship between WFC and continuance commitment. Continuance commitment occurs when the gains or losses that an individual would have in case of continuing or leaving the organization are important to him, or when there are not any job opportunities.

Factors influencing continuance commitment from this study may be associated with professional benefits derived from the hospitals or other

opportunities available in the Cape coast metropolis. During the interview, it was noted that most of the respondents will not leave their hospitals because of professional growth. For instance, acquiring surgical skills is key in the medical profession. Those with the surgical departments such as Surgery, Obstetrics and gyaenacology, alluded that they have acquired their skills because of close supervision of their bosses and their willingness to impact knowledge and may not have acquired those skills anywhere. Also majority of the respondents interviewed said because there is no transfer with the Cape Coast Teaching Hospital and University of Cape Coast Hospitals unless voluntarily, one can work there throughout his career life. This helps with proper planning of life, spouse's work and kids' education especially the primary level will not be affected. But in the case of Ghana health services one can get unexpected transfer from one hospital to another which may be in a different region. This may distort family life. Finally, there are a lot of opportunities in cape coast such as getting part time teaching appointment at University of Cape Coast Allied health sciences or any of the Nurses training colleges.

The third finding of the study indicates that as the normative commitment to the organization increases, the work–family conflict increases; or vice versa, as the normative commitment decreases, so does the work–family conflict. This result however is not in conformity with the studies by Meyer et al. (2002) and Samuel, (2007). In their studies, they reported no statistically significant relationship between these two variables. However the finding of this study confirms with studies by Babalola et al. (2015), Mukanzi and Senaji (2014), Serap and Sonmez (2012). Normative commitment

normally occurs when an individual takes organizational commitment as his/her duty, and thinks that it is the right thing to commit to the organization. Some respondents of this study think that the challenges faced by their hospital will be the same for almost all other hospitals so no need to leave but help to make it a better place to work. People with such notion will remain commited and may not consider to leave the hospital. Those who had already been sponsored for their postgraduate program are bonded to serve for some number of years. Even if they are offered a better job elsewhere, have to be loyal so that their other colleagues will also get that opportunity.

Ibn Lijeri and Sonmez (2012) carried out a study on organizational commitment and work-family conflict among doctors and nurses in Ankara and the results showed that there is a reverse relation between organizational commitment with work-family conflict. Thus committed physicians and nurses experienced more work-family conflict. Based on the results in this study, it can be said that if the doctors are supported to create more balance between work environment and family environment, there will be a reduction in WFC.

According to Silverthorne, (2005), a person with high commitment to the organization is less peaceful and more prone to conflict because he cannot fulfill his responsibilities in the family. This may also be the reason why as the organizational commitment of the medical practitioners in this study increases, the degree of conflict between their work and family roles also increases. In Ghana, the general satisfaction level of the medical practitioners is quite low, (Owusu, 2017). One of the reasons is the high doctor to patient ratio, 1 to 10, 450 ratio (Owusu, 2017). Under these circumstances, it is not surprising that

the medical practitioners, who give priority to their working places always requiring more time and energy from them, will experience work–family conflict. Therefore, as the organizational commitment of the medical practitioners in the study increases, so does work–family conflict. It can be said that these doctors, may have personal coping strategies that enable them to have high organizational commitment.

One of the most important premises of organizational commitment is the perceived organizational support (Meyer et al., 2002). As a result of the support of the organization to balance work–family life, the organizational commitment of the employees increases, (Casper & Buffardi, 2004; Spinks, 2004). In other words, hospitals should try and take precautions to decrease their work–family conflicts. Based on the response to the interview questions, it can be generalized that the respondents of this study were committed to their profession.

Implications of the Study

This study revealed that FWC dimensions are the main variables to affect organizational commitment in the current investigation, where they (WFC dimensions) have effect on organizational commitment.

Furthermore, it has been revealed that WFC has a significant positive effect on affective, continuance and normative commitments on a whole. However, the relation was weak even though it was significant. This was explained by the smaller coefficient of determination (R-squared) values recorded for the models generated. This study was important to raise questions on how different cultures might influence the relationship between WFC and organizational commitment. In today's world, multinational companies should

be aware of different cultures and social norms to act effectively in the given context and increase their legitimacy. One way for this is to help individuals to balance their family and work responsibilities, especially in collectivist cultures. By this way, both individuals and organizations will benefit with increased commitment, satisfaction, and general performance.

Chapter Summary

The chapter begun with an introduction of the chapter and what it entailed. The analysis of the study was carried out based on the research objective/questions/hypothesis. The internal constituency of the research instrument. SPSS was used in the analysis of the data. Tables were used to represent the data. Three hypotheses were tested in all. Multiple regression analysis was carried out. All the hypotheses tested were significant positive. These conclusions were not in conformity with earlier assertions by other researchers that there is a significant negative relationship between WFC and organizational commitment. The chapter ended with discussions of findings as well as implications of the study in general.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of the study is to examine the effects of work-family conflicts on organizational commitment of medical practitioners in hospitals in Cape Coast. Three different hypotheses underpinned the study. These are relationship between work-family conflict and; Affective Commitment, Continuance Commitment and Normative Commitment. The chapter also presents the results of the study based on the data analysis made in chapter four. Other areas covered include summary of findings, conclusions, and implications of the study, as well as recommendations and suggestions for further studies.

Summary of Study

The purpose of the study is to examine the effects of work-family conflicts on organizational commitment of medical practitioners in hospitals in Cape Coast. Both qualitative and quantitative research methods were used. The results were processed with SPSS v 20 and analyzed with ANOVA. The summary of findings is presented below.

Demographic Characteristics of Respondents

The study revealed that majority of the respondents (54%) were males and females were 46%. Another 87.2% of them are working at Teaching Hospitals. Also, 87.2% normally do work during weekends. Moreover, 34.80% and 42.0% of them are Medical and House Officers respectively. In addition, 62.8% of them run night duties sometimes. When the respondents

were asked how often they run the night duties in a month, it was observed that another 34.8% of them run night duties 3 to 4 times every month.

Similarly, the mean age of the medical practitioners in the sample was about 32 years, with a standard deviation of 0.459. The oldest person is 62 years whiles the youngest is 20 years. Also, the maximum number of children by medical practitioners was 5. There were medical practitioners who don't have children at all. The mean work experience of respondents was about 6 years whiles the highly experienced persons have worked at the various organizations for the past 35 years and the least work experience was those with only one year. The mean hour a medical practitioner in the sample works in a day was observed to be about 9 with a corresponding standard deviation of 3.225. The minimum hour a medical practitioner works is 4 and the maximum is 24 hours.

Relationship between WFC and Affective Commitment

It was observed that TBC predicts organizational commitment positively and it has increasing creasing effect. Also, SBC negatively predicts organizational commitment and it has decreasing effect. BBC positively predicts organizational commitment and it has an increasing effect. Only 8.3% of the changes of affective commitment are explained by WFC while 91.7% is determined by other factors. It was also observed that WFC has significant effect on affective commitment.

Relationship between WFC and Continuance Commitment

It was observed that TBC does not predict organizational commitment but has increasing creasing effect. Also, SBC negatively predicts organizational commitment and it has decreasing effect. BBC positively

predicts organizational commitment and it has an increasing effect. About 3.7% of the changes of affective commitment are explained by WFC while 96.3% is determined by other factors. The results show that WFC has significant effect on affective commitment.

Relationship between WFC and Normative Commitment

It was observed that TBC does not significantly improve the prediction of normative commitment. Also, SBC does not improve the prediction of organizational commitment organizational. Only BBC positively significantly improves the prediction of normative commitment and it has an increasing effect. Five (5%) of the changes in normative commitment are explained by WFC while 95% is determined by other factors. The results show that WFC has significant effect on normative commitment.

Conclusions

The current study determines the effect of WFC on organizational commitment (affective, continuance and normative commitment) among employees of medical practitioners in hospitals in Cape Coast. The findings of the study revealed that WFC on a whole has a positive impact on organizational commitment (affective, continuance and normative commitment) of employees which supports the stated research hypotheses.

This means WFC factors such as (Time-Based Conflict, Strain-Based Conflict and Behaviour-Based Conflict) have a reasonable influence on organizational commitment (affective, continuance and normative commitment).

Recommendations

Based on the summary of findings and conclusions, the following recommendations were made in order to balance the organizational commitment with the WFC, hospital management have a role to play. They Should take measures to reduce working hours, raise income, provide opportunities for career development and training, encourage support of healthcare staff from senior managers, reduce work stress and balance work–family conflict. Health institutions consequently, should begin to consider including elastic working policies or expand the existing ones to support employees to balance their work and family lives as well as presenting atmospheres where individuals can handle family responsibilities better and focus on their job performance as well.

They can also organize programs like child care, preschools, educational package, health care benefits, promotions, special leaves, extra duty allowances and bonuses. For example if there is a crèche attached to hospitals, workers can leave their children there whilst they work. Furthermore they should inform medical practitioners of work-family policies available to them and encourage them to use the systems, organize workshops and sessions to reduce work-family conflict. Finally, they should create consulting centers in the hospitals for employees to solve family problems.

Suggestions for Further Study

The current study only investigates WFC focusing on time-based conflict, strain-based conflict and behavior-based conflict dimensions. Future studies should be conducted with similar patterns utilizing other dimensions of WFC such as Work interfering with family (WIF) and Family interfering with

work (FIW). Also, further study should be extended with the addition of control effect of other variables like culture and ethnicity, marital status, age, number of children, among others using larger sample sizes. These results have implications for hospital administration to design workloads that reduce WFC in employees and increase organizational commitment.

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APPENDICES

APPENDIX A

CONSENT FORM

UNIVERSITY OF CAPE COAST

MBA (GENERAL MANAGEMENT)

RESEARCHER: AGNES ACHIAMAA ANANE

STUDY TITLE: THE RELATIONSHIP BETWEEN WORK- FAMILY CONFLICT AND ORGANIZATIONAL COMMITMENT AMONG THE MEDICAL PRACTITIONERS IN CAPE COAST METROPOLIS.

General Information about the Research

This research seeks to assess if work family conflict exists among medical practitioners and its effect on organizational commitment. The research will be conducted from April 2018 to June 2018.

Potential Risks: There are no potential risk for participating in this research.

Benefits: There is no direct benefit for participating in the study, however your participation will help identify the kind of work family conflict that doctors experience and how best hospital management can help in achieving work family balance in order to promote organizational commitment**.**

Confidentiality: All possible steps have been taken to ensure your privacy. The questionnaire you fill has been assigned an arbitrary code number which will be use throughout the study. Only this code (not your name) will be used when analyzing or reporting the data in order to ensure confidentiality**.**

Voluntary Participation and Withdrawal: Participation in the research is voluntary. You are free to withdraw at any time and this will have no effect on you.

Agreement: By signing this document, I am stating that I understand that the data obtained is for research only. I the undersigned, hereby, consent to be a participant in this study.

Signature of participant……

Date ……..……

APPENDIX B

QUESTIONNAIRE

UNIVERSITY OF CAPE COAST

SCHOOL OF BUSINESS

This questionnaire is designed and being circulated to collect data for research on the topic:

"The Relationship Between Work-Family Conflict and Organizational Commitment Among the Medical Practitioners in Cape Coast".

The usefulness of this research depends on your careful and frank response. You are fully assured that the responses will only be used for academic purposes and kept completely confidential. Your co-operation will be highly appreciated.

Please answer the following questions by ticking [√] the appropriate response.

SECTION A:

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Gender: a) M b) F
2. Age……
3. Indicate the number of your children……..……
4. Indicate their ages……
5. Marital status……..……
6. Organization:

   a) Ghana Health Services b) Teaching Hospital c) Private Hospital

7. Cadre:

a) House officer b) Medical officer c) Resident d) Specialist d) Consultant

8. How long have you been working? ……..……

9. How many hours do you work a day?.....……..……

10. Do you work over the weekend? a) Yes b) No

11. Do you run night duties? a) Yes b) No

12. If yes how often per month: a) 1-2 b) 3 – 4 c) 5-6 d)7-8 e) 9-10 f)>10

SECTION B:

FAMILY-WORK CONFLICTS

Please use a 5-point scale measuring from "1=Strongly Disagree" to "5=Strongly Agree" to provide responses to the following items by ticking [√] the appropriate box:

Time-Based Conflicts					
Statements	**1**	**2**	**3**	**4**	**5**
My work keeps me from my family activities more than I would like					
The time I must devote to my job keeps me from participating equally in my household responsibilities and activities					
I have to miss family activities due to the amount of time I must spend on work responsibilities					
The time I spend on family responsibilities often interferes with my work responsibilities					
The time I spend on family often causes me not to spend time in activities at work that could be helpful to my career					
I have to miss work activities due to the amount of time I must spend on family responsibilities					
Strain-Based Conflicts					
Statements	**1**	**2**	**3**	**4**	**5**
When I get home from work, I am often too frazzled` to participate in family activities					
I am often emotionally drained when I get home from work that it prevents me from contributing to my family					

Due to the pressure at work, sometimes when I come home I am too stressed to do all the things I enjoy					
Due to stress at home, I am often preoccupied with family matters at work					
Because I am often stressed from family responsibilities, I have a hard time concentrating at work					
Tension and anxiety from my family life often weakens my ability to do my job					
Behaviour-Based Conflicts					
Statements	**1**	**2**	**3**	**4**	**5**
The problem-solving behaviors I use in my job are not effective in resolving problems at home					
Behaviors that is effective and necessary for me to at work would be counterproductive at home					
The behaviors I perform that make me effective at work do not help me to be a better parent or spouse					
The behaviors that work for me at home do not seem to be effective at work					
Behaviors that is effective and necessary for me to at home would be counterproductive at work					
The problem-solving behaviors I use in my job are not effective in resolving problems at home					

SECTION C: ORGANIZATIONAL COMMITMENTS (OC)

OC1: Affective Commitment

Please use a 5-point scale measuring from "1=Strongly Disagree" "2=Disagree", "3=moderately", "4=Agree" and "5=Strongly Agree" to provide responses to the following items by ticking [√] the appropriate box:

Statements	1	2	3	4	5
I do not feel a strong sense of belonging to this hospital					
I do not feel emotionally attached to this hospital					
This hospital has a great deal of personal meaning for me					
I would be very happy to spend the rest of my career with this					
I enjoy discussing about my hospital with people outside it.					
I really feel as if this hospital's problems are my own					
I think I could easily become attached to another hospital as I am with this one					
I do not feel like 'part of the family at my hospital'					

OC2: Continuance Commitment

Please use a 5-point scale measuring from "1=Strongly Disagree" "2=Disagree", "3=moderately", "4=Agree" and "5=Strongly Agree" to provide responses to the following items by ticking [√] the appropriate box:

Statements	1	2	3	4	5
I feel I have too few options to consider leaving this hospital					
It will be hard for me to leave my hospital right now, even if I want to.					
I am not afraid of what might happen if I quit my job without having another lined up					
I don't intend to leave this hospital voluntarily					
I owe a great deal to my hospital					
I am willing to put in great deal of effort beyond that					

normally expected to help my clients and the hospital					
I feel very little loyalty to this hospital					
I would accept almost any type of job assignment in order to keep working for this hospital					
This hospital has a great deal of personal meaning for me					
I feel proud to work in this hospital for the rest of my life					
I owe a great deal to this hospital					

OC3: Normative Commitment

Please use a 5-point scale measuring from "1=Strongly Disagree" "2=Disagree", "3=moderately", "4=Agree" and "5=Strongly Agree" to provide responses to the following items by ticking [√] the appropriate box:

Statements	**1**	**2**	**3**	**4**	**5**
I think that doctors these days move from hospital to hospital too often					
I don't believe that a person should be loyal to his or her hospital					
Jumping from hospital to another does not seem at all unethical to me					
If I got offer for a better job elsewhere, I would not feel it was right to leave my hospital					
I was taught to believe in the value of remaining loyal to one organization					
Things were better in the days when people stay in one organization for most of their career					
I believe loyalty is important and therefore feel a sense of moral obligation to remain					
I do not think that to be a doctor is sensible anymore					

THANK YOU FOR YOUR TIME AND CO-OPERATION

APPENDIX C

INTERVIEW QUESTIONS

1. Do you experience Work family conflict?

   Yes or no

2. If yes how will you rate it on a scale of 10)

3. Have you ever considered leaving the hospital you are working for?

   If yes , why

   If no, why

4. Do you regret being a medical doctor?

   If yes, why

   If no, why