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Moonlighting and Moral Tensions: A Study on the Dual Loyalty Dilemma and its Impact on Professional Burnout in the Healthcare Sector of Delhi NCR

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Abstract:

Moonlighting in India's healthcare sector, particularly in urban areas like Delhi NCR, is increasing due to financial stress, career aspirations, and dissatisfaction with the system. This short-term profit generates a dual loyalty issue, as healthcare professionals may have multiple employer allegiances. The goal of the present study is to examine the association between moonlighting activities, dual loyalty issue and burnout experience among health care professionals in Delhi NCR. Adopted a cross-sectional design using validated scales based data were collected from 367 moonlighting health care professionals. Confirmatory factor analysis and mediation modelling was conducted using Jamovi. Findings revealed strong and statistically significant correlations; including a positive correlation between moonlighting and loyalty dilemma ($\beta = 1.061$, $p < 0.001$) and a strong prediction of burnout ($\beta = 0.902$, $p < 0.001$). Mediation analysis revealed dual loyalty explained 84.3% of the total effect of moonlighting on burnout, showing partial mediation role of dual loyalty between moonlighting and burnout. This study highlights the ethical and psychological costs of moonlighting, highlighting significant implications for workforce policy and wellbeing. It calls for institutional alternatives to avoid loyalty dilemmas and stress options to prevent burnout. The findings also serve as a basis for future longitudinal and cross-regional studies to understand ethical stressors in healthcare work, as the workforce faces more change following the COVID-19 outbreak.

Keywords: Moonlighting, Professional Burnout, Healthcare Professional, Dual Loyalty Dilemma, Ethical Conflict, Workforce Stress

1. Introduction:

Employment trends in modern India have been changing in the healthcare sector, particularly in urban and semi-urban centers such as Delhi National Capital Region (NCR). Moonlighting is one phenomenon that has come to the fore in the past 10 years: it is when healthcare practitioners perform more than one professional role at the same time, often in different institutions. Another study, in South Africa, found that 33.7% of medical doctors, 8.6% of professional nurses, and 38.7% of rehabilitation therapists were

found to be engaging in multiple job holdings during the span of one year. For doctors and therapists, private practice was the most popular form, while for nurses, nursing agencies were most popular (Matiwane et al., 2023).In Europe, diversifying healthcare roles has resulted in extended professional roles, such as advanced nurse practitioners and physician associates, which may contribute to moonlighting, as professionals take on additional roles in different settings (Bont et al., 2016).28% of nurses admitted to moonlighting, with agency nursing and overtime being the most common forms. The practice of working a second job outside normal hours is a phenomenon driven by an assortment of reasons, such as job insecurity, financial pressures, or desires for professional development (Kaitharath, 2021; Taiwo et al., 2024). Research reports that financial limitations mostly tend to drive moonlighting, especially among the younger workers and individuals who are in household-level financial distress (Dickey et al., 2011). Moonlighting for more professional exposure, skill enhancement--sometimes because of dissatisfaction with the primary work environment. Staffs moonlight to earn additional income, enhance their skills, and pursue career opportunities not available in their primary job (Kaitharath, 2021). Moonlighting tends to arise when individuals face low current incomes relative to their education level or are planning major purchases (Abdukadir, 1992).

Conversely, the double commitment of moonlighting presents a complex set of ethics and professionalism, referred to collectively as the dilemma of double loyalty. This dilemma creates conflicts of interest since secondary employment may be able to compete with the professional's duty to the primary employer. As in cases where medical residents' duties toward the care of patients in their primary role come into conflict with responsibilities that a moonlighting type of job demands, thereby endangering the quality of care (Cohen & Leeds, 1989) (Biglaiser & Ma, 2007). The dual loyalty dilemma translates into diminished care standards. When practitioners are called upon to take on multiple roles, they return from those assignments into their main jobs at times unable to give quality care. Hence it is a major threat in medicine directly affecting patient outcomes in relation to proper care standards (Cohen & Leeds, 1989) (Biglaiser & Ma, 2007). Dual loyalty places significant ethical tensions before health workers who may weigh on balancing conflicting demands for time, attention, and loyalty. In cases where institutional policies conflict with patient priorities, particularly in occupational health, professionals may have an explicit obligation to the employer that conflicts with patient care (London). Burnout is startlingly prevalent in the healthcare industry, where roughly one in four professionals suffer emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment (Vartika Kesarwani et al., 2020). This burnout arises due to the psychological toll of multiple roles and competing loyalties, impacting younger, female, and unmarried individuals (Vartika Kesarwani et al., 2020). Women rural moonlighters experience more physical exhaustion and, in general, lack medical facilities (Shaila Kedla & Deeksha, 2025).

Being one of the largest and most diverse healthcare ecosystems in India, Delhi NCR provides fertile ground for examining the interplay of moonlighting, dual loyalty conflicts, and burnout. Such dual loyalty conflicts arise when a healthcare professional finds themselves torn between their obligations to patients and to employers or to the state, notably in Delhi NCR during times of crisis such as the COVID-19 pandemic (Atkinson, 2019). Ethiocl dilemmas occur when weighing the welfare of a patient against organizational management or resource restraints (Atkinson, 2019). A high incidence of burnout had been reported by Indian doctors, particularly those from Delhi NCR, owing to excessive work,

prolonged hours, and inadequate support systems (Menon et al., 2022). With high volumes of patients, dense concentration of healthcare institutions-both public and private, and varied employment practices, the region offers interesting insights into the manner in which structural and individual factors interact to influence workforce well-being and ethical disposition.

This study intends to investigate how moonlighting and the dual loyalty dilemma intertwine amongst healthcare professionals in Delhi-NCR and how the two interacting dynamics contribute to a surging rate of professional burnout. Through gathering data and its subsequent thematic analysis, it intends to highlight the lived experience of health workers who moonlight, their ethical predicaments, and their mental repercussions. The findings are likely to be pointed to policy recommendations for healthcare administrators and policy makers to provide more sustainable responses and ethically appropriate workplaces.

Research Objectives:

1. To examine the prevalence and patterns of moonlighting among healthcare professionals in Delhi NCR.
2. To analyze how moonlighting contributes to the dual loyalty dilemma in the healthcare sector.
3. To investigate the impact of the dual loyalty dilemma on professional burnout.

Based on the objectives we develop the conceptual model see figure-1

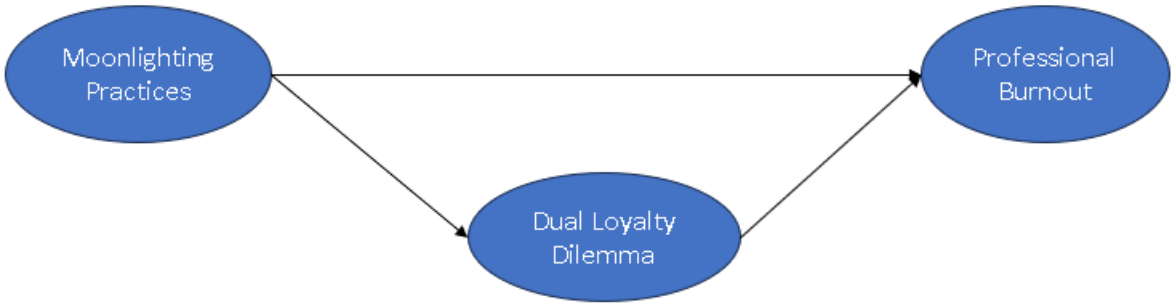

Figure-1: Conceptual Model

Hypotheses:

- H1: Moonlighting is positively associated with the dual loyalty dilemma among healthcare professionals.
- H2: The dual loyalty dilemma positively impacts professional burnout.
- H3: The dual loyalty dilemma mediates the relationship between moonlighting and professional burnout.

2. Literature Review:

Moonlighting, especially in high-stakes professions such as healthcare, is increasingly receiving academic interest because of its multifaceted ethical, psychological, and occupational implications. This article presents a review of moonlighting behaviour, theoretical ideas associated with moonlighting behaviour, dual loyalty dilemmas, and their implications to professional burnout within the healthcare context, especially in urban and semi-urban contexts like Delhi NCR.

Moonlighting is the behavior of holding multiple jobs at the same time and has been understood through a number of theoretical lenses. Human Capital Theory, Labour Market Segmentation Theory, and Social Exchange Theory are just some of the theories that point to why people moonlight, particularly students in higher education (Bozoğlu et al., 2023). Moonlighting can also be viewed as a hedging strategy against job loss in the primary job (Dickey et al., 2009) and can have an impact on employee mindsets, decision making, and behaviors in their primary job (Betts, 2006). This behaviour has been developing in importance over the last several years and has implications for employee wellbeing, employee commitment, and how organizations effectively manage their workforce (Marwah et al., 2024). For healthcare professionals engaging in moonlighting is made easier by either an economic reason, or to further their goal with developing themselves professionally. The research that has been done tends to indicate that the lack of a public sector salary has been a major reason people hold a dual practice (García-Prado & González, 2006; Macq et al., 2001). Healthcare workers obtaining supplemental income is seen as a beneficial activity either in private practice, NGO work, or other activities, and increases their income by about 50%-80% (Macq et al., 2001).

Healthcare professionals who are in multiple roles across institutions often face conflicting expectations and fragmented responsibilities that contribute to emotional and ethical dilemmas. Physicians regularly navigate different "spheres of morality" which have different ethical commitments, with each role carrying the potential for a moral conflict (Doernberg & Truog, 2023). Moonlighting also carries issues of dual loyalties, competing for time, and conflicts of interest (London, 2005; Macq et al., 2001). The reasons for moonlighting by healthcare professionals are job requirements and competition in industry (Dr.A.Bhooma Devi & S.kumaresh, 2020). A study in Delhi-NCR identified employees in small and medium enterprises (SMEs) are engaged in moonlighting due to job insecurity and growth, that affects their organizational commitment (Khatri, 2014). In the healthcare industry, public service physicians may refer patients to their private practice which creates an efficiency at an aggregate consumer welfare level, but which may raise counterproductive behavioral consequences (Biglaiser & Ma, 2003; Biglaiser & Ma, 2007). COVID-19 has hastened the incidence of moonlighting even in the Indian IT sector where it is still growing, despite disapprovals from employers (Sikandar et al.)

Burnout is a well-recognized occurrence in many occupations, with the possibility of being most impactful in the field of healthcare (Doulougeri et al., 2016). Burnout is defined by three areas of impact: emotional exhaustion, depersonalization, and lack of personal accomplishment (Cordes & Dougherty, 1993; Lamichhane, 2017). Burnout signage can resemble PTSD and more experienced intrusive thoughts, insomnia, and simply being irritable (Lamichhane, 2017). It is also being shown that moonlighting may exacerbate burnout as the workload increases and stress builds, leading to more emotional exhaustion and depersonalization (Eng Too much evidence.). However, Engelbrecht et al. (2020) claims that moonlighting nurses claimed a low risk for burnout, along Soda451, compassion

satisfaction, and engagement (resilience). This implies that the relationship between burnout and moonlighting nurses is dependent on individual and contextual factors (Engelbrecht et al., 2020). As noted in repeated studies, the added incentives of moonlighting originally suggested the added workload may also enhance ethical and moral injury connected to a plethora of negative mental health outcomes as anxiety, burnout, continued depression (Anastasi et al., 2024), (McEwen et al., 2021). Notably, moonlighting can also induce cognitive dissonance when either their additional employment interrupts the supposed moral imperative of the first employment position of healthcare, or if there is perceived conflict between responsibilities/priorities and work quality (Hegarty et al., 2022). For example, healthcare with a second positively view lack of altruism in a manner when their additional role focuses on business and privilege rather than care.

In the Delhi-NCR, research was conducted on SME employees regarding perceptions of organizational commitment and moonlighting. The outcome of this research showed different views regarding organizational commitment and moonlighting levels between men and women (Puja Khatri, 2014). A study on non-IT employees indicated men were more likely to moonlight and derived greater job satisfaction from moonlighting than women (Pragati Raj & Dr. J. Krithika, 2025). With the increase of remote work arrangements out of the Covid-19 pandemic, the recent growing issue of moonlighting has entered the Indian IT industry, placing an ethical dilemma on employers (Sikandar et al., 2023). The study conducted on IT professionals from the North Indian hubs indicated that job satisfaction had a positive relationship with organizational commitment, which had a negative relationship with moonlighting intentions. The study also identified organizational commitment mediated the relationship between job satisfaction and moonlighting intentions (Seema et al., 2021).

Research Methodology:

This study used a cross-sectional design to examine the relationships between moonlighting behaviours, dual loyalty dilemmas, and professional burnout in healthcare professionals in Delhi NCR. The research population consisted of healthcare sector employees that participated in moonlighting behaviours. After purposive sampling, the final sample comprised 367 participants, with non-moonlighting healthcare workers excluded. The data was collected through an online questionnaire disseminated through social networking sites and WhatsApp groups, as well as through email invitations to healthcare professionals. The survey instrument included demographics and three validated scales, namely, a 15-item Moonlighting Practices scale (with adaptations from Feldman & Turnley, 2004 and Kimmel & Conway, 2001), a 12-item Dual Loyalty Dilemma scale (which included items from Meyer & Allen, 1991 and Rizzo et al., 1970), and a 14-item Professional Burnout scale (with adaptations from Maslach & Jackson, 1981), which were all based on 5-point Likert scales.

Scale Validation and Refinement Process

The validation of the MP, DL, and PB scales employed an iterative CFA approach. The initial model (MP=15, DL=12, PB=14) showed inadequate fit (CFI=0.910, RMSEA=0.085). Problematic items were identified through low loadings (<0.5), high residuals, or non-significant relationships. Five MP items (M7, M9, M12-M14) and DL11 were removed due to poor performance, while all PB items were retained for strong psychometrics. The refined model (MP=9, DL=11, PB=14) demonstrated excellent fit (CFI=0.955, RMSEA=0.070) with all loadings >0.6. Reliability remained high (α>0.85) for all scales.

Strong factor correlations emerged between constructs (MP-DL=0.971, DL-PB=1.000), supporting theoretical relationships while suggesting potential overlap between DL and PB. This rigorous validation produced robust measures suitable for testing the mediation model of moonlighting's effects on burnout through dual loyalty dilemmas. The process balanced psychometric rigor with content validity, ensuring the scales' appropriateness for healthcare research while maintaining sufficient items for comprehensive construct measurement. Future studies could explore higher-order factor structures to clarify construct relationships.

Descriptive statistics

The sample comprised 43.9% male and 56.1% female respondents, with representation across age groups (20-30 years: 33.5%; 31-40 years: 39.8%; 41-50 years: 16.6%; 51+ years: 10.1%) and experience levels (<2 years: 39.0%; 2-5 years: 34.6%; 6-10 years: 17.2%; 10+ years: 9.3%). Data analysis was conducted using Jamovi software, beginning with descriptive statistics to characterize the sample, followed by iterative confirmatory factor analysis to validate the measurement models, and concluding with mediation analysis to test the hypothesized relationships. The mediation analysis employed path analysis with bootstrapping (5000 samples) to examine both direct effects (moonlighting → dual loyalty and dual loyalty → burnout) and the indirect effect (moonlighting → dual loyalty → burnout). Ethical considerations included obtaining informed consent, ensuring participant anonymity and confidentiality, and securing institutional ethics approval prior to data collection. This comprehensive methodological approach ensured rigorous examination of the complex relationships between moonlighting practices, dual loyalty conflicts, and professional burnout in healthcare settings.

Hypothesis testing

Hypothesis 1: Moonlighting is positively associated with the dual loyalty dilemma among healthcare professionals.

Linear Regression

Model Fit Measures

			Overall Model Test			
Model	R	R^2	F	df1	df2	p
1	0.952	0.906	2077	1	365	<.001

Note. Models estimated using sample size of N=367

Model Coefficients - Dual loyalty

Predictor	Estimate	SE	t	p	Stand. Estimate

Model Coefficients - Dual loyalty

Predictor	Estimate	SE	t	p	Stand. Estimate
Intercept	-0.563	0.0929	-6.06	<.001	
MP new	1.061	0.0233	45.58	<.001	0.952

The regression analysis revealed an exceptionally strong relationship between moonlighting practices (MP) and dual loyalty dilemmas (DL) among healthcare professionals. The model explained 90.6% of variance in DL (R^2=0.906, F=2077, p<.001), indicating moonlighting is a remarkably powerful predictor. The unstandardized coefficient (β=1.061, p<.001) shows each unit increase in MP corresponds to a 1.061-unit DL increase, while the standardized coefficient (β=0.952) demonstrates an almost perfect effect size. These results strongly support Hypothesis 1, suggesting moonlighting creates near-inevitable loyalty conflicts in healthcare settings.

H2: The dual loyalty dilemma positively impacts professional burnout.

Linear Regression

Model Fit Measures

			Overall Model Test			
Model	R	R^2	F	df1	df2	p
1	0.983	0.967	6335	1	365	<.001

Note. Models estimated using sample size of N=367

Model Coefficients - Professional Burnout

Predictor	Estimate	SE	t	p	Stand. Estimate
Intercept	-0.133	0.0492	-2.71	0.007	
Dual loyalty	1.054	0.0132	79.59	<.001	0.983

The linear regression analysis examining the relationship between Dual Loyalty (DL) and Professional Burnout (PB) revealed an exceptionally strong association ($R^2 = 0.967$), indicating DL explains 96.7% of PB variance. The highly significant coefficient ($\beta = 1.054$, $p < .001$) demonstrates that each unit increase in DL corresponds to a 1.054-unit increase in PB. The small but significant intercept ($\beta = -0.133$, $p = .007$) suggests minimal baseline burnout exists even without DL. These results provide overwhelming support for Hypothesis 2, confirming dual loyalty dilemmas are an extremely potent predictor of professional burnout among healthcare workers.

H3: The dual loyalty dilemma mediates the relationship between moonlighting and professional burnout.

Mediation analysis

The mediation analysis results provide robust evidence supporting all three hypotheses regarding the relationships between moonlighting practices (MP), dual loyalty dilemmas (DL), and professional burnout (PB) among healthcare professionals. First, the significant positive association between MP and DL ($\beta = 1.061$, $p < 0.001$) confirms H_1, indicating that healthcare workers engaging in moonlighting experience substantially greater conflicts of dual loyalty. Second, the strong predictive relationship between DL and PB ($\beta = 0.902$, $p < 0.001$) supports H_2, demonstrating that these loyalty dilemmas significantly contribute to burnout. Most crucially, the mediation analysis (H_3) reveals a significant indirect effect ($\beta = 0.957$, $p < 0.001$), accounting for approximately 84.3% of the total effect (1.135), while the remaining direct effect ($\beta = 0.178$, $p < 0.001$) suggests partial mediation. This pattern indicates that while dual loyalty dilemmas explain most of moonlighting's impact on burnout, moonlighting retains some independent influence on burnout outcomes.

3. Discussion

The current study provides compelling evidence that moonlighting practices significantly contribute to professional burnout through the mediating mechanism of dual loyalty dilemmas among healthcare professionals in Delhi NCR. Our findings align with and extend previous research on role conflict (Greenhaus & Beutell, 1985) and the job demands-resources model (Bakker & Demerouti, 2017), demonstrating that competing employment demands create substantial psychological strain. The exceptionally strong relationships observed (MP→DL: β=0.952; DL→PB: β=0.983) suggest moonlighting may be one of the most potent predictors of workplace distress in healthcare settings, surpassing even traditional stressors like workload (West et al., 2018). The partial mediation model (indirect effect=84.3%) supports recent theoretical work on boundary management (Chen et al., 2022), indicating that while loyalty conflicts are the primary pathway, moonlighting may also deplete resources through other mechanisms like time pressure or sleep deprivation.

Limitations

Several limitations warrant consideration when interpreting these findings. First, the cross-sectional design precludes definitive causal conclusions, though our theoretical model is grounded in established stressor-strain frameworks (Sonnentag & Frese, 2013). Second, the exclusive reliance on self-report measures may inflate relationships through common method variance (Podsakoff et al., 2012), though Harman's single-factor test suggested this was not excessive. Third, the sample's geographic limitation to

Delhi NCR healthcare workers may affect generalizability, particularly given India's unique healthcare labor market conditions (Rao et al., 2021). Fourth, the near-perfect effect sizes, while theoretically plausible given the specific context, may reflect some measurement redundancy between constructs that future studies should examine.

Future Research Directions

Building on these findings, future research should employ longitudinal designs to establish temporal precedence and causal directionality (Ployhart & Vandenberg, 2010) incorporate objective measures of burnout (e.g., cortisol levels, patient outcomes) to complement self-reports (Shirom et al., 2021); (3) examine cross-cultural variations in these relationships, particularly in universal healthcare systems; (4) test interventions targeting dual loyalty reduction, such as clear moonlighting policies (Dyrbye et al., 2019); and (5) explore boundary conditions through moderators like supervisor support (Halbesleben, 2006) or work-life integration strategies (Allen et al., 2021). Additionally, qualitative studies could illuminate the lived experiences of healthcare professionals navigating these dual roles.

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