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Investigation of Burnout and Mobbing Levels of Assistant Physicians

Asistan Hekimlerin Tükenmişlik ve Mobbing Seviyelerinin İncelenmesi

Begüm GENÇELLİ

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ABSTRACT

This study examines the effect of mobbing on the burnout of assistant physicians and also to determine whether the mobbing and burnout differ according to sociodemographic features. “Mobbing Scale” and “Burnout Inventory” which were developed by the researcher, were used as data collection tools. The data collected from the assistant physicians who are working in public and private university hospitals and training, and research hospitals, which are operating in Turkey.

Frequency, percentage value, mean and standard deviation analyzes were performed on the obtained data. Factor analysis was performed to determine the validity of the scales, and the Cronbach Alpha coefficient was applied to determine the internal consistency. Also, independent sample t-test, one-way variance analysis were used to determine the differences between variables. Correlation analysis was used to establish the relationships between variables and simple regression analysis was used to reveal the effect of mobbing on burnout.

According to the results obtained in the research, the exposure of the mobbing is at a medium level, and the perception of burnout is at a high level. There is a significant positive relationship between exposure of the mobbing and burnout levels. Generally, burnout levels were examined in two dimensions. These are emotional dissatisfaction and behavioural alienation. The mobbing behaviours that affect the stated burnout levels consist only of the “chef’s intimidation behaviour’ dimension. However, there is a significant and positive relationship between mobbing behaviours and these variables. As a result, the “intimidation behaviours by the chief’ dimension is seen as an essential reason in each dimension that increases the general burnout of the assistant physicians. Also, the burnout levels of the participants who are exposed to mobbing increase and the well-being of the participants who experience this process are significantly affected by the interaction between mobbing and burnout.

Keywords: Health sector, assistant physicians, mobbing, chef’s intimidation behaviours, emotional dissatisfaction, behavioural alienation.

ÖZET

Bu araştırma, mobbing davranışlarının asistan hekimlerin tükenmişliği üzerine etkisini incelemek ve mobbing ile tükenmişlik değişkenlerinin bazı demografik özelliklere göre farklılık gösterip göstermediğini belirlemek amacıyla gerçekleştirildi. Veri toplama aracı olarak, araştırmacı tarafından geliştirilmeye çalışılan "Mobbing Ölçeği"ile "Tükenmişlik Ölçeği" kullanıldı. Araştırmada kullanılan veriler Türkiye'de bulunan devlet üniversite hastaneleri, özel üniversite hastaneleri ile eğitim ve araştırma hastanelerinde görev yapan asistan hekimlerden elde edildi. Elde edilen verilere, frekans, yüzde değeri, aritmetik ortalama ve standart sapma analizleri ile birlikte, ölçeklerin geçerliğini belirlemek için faktör analizi, iç tutarlılığını belirlemek için ise Cronbach Alpha güvenlik katsayısı uygulaması yapıldı. Ayrıca, değişkenler arasındaki farklılıkları belirlemek için bağımsız örneklem t testi ve tek yönlü varyans analizi, değişkenler arasındaki ilişkileri belirlemek için korelasyon analizi ve mobbingin tükenmişlik üzerindeki etkisini tespit edebilmek için de basit regresyon analizi yapıldı. Araştırmada elde edilen sonuçlara göre, asistan hekimlerin mobbing davranışlarına maruz kalma orta düzeyde iken tükenmişlik algılamaları ortadan yüksek düzeydedir. Mobbinge maruz kalmaları ve tükenmişlik düzeyleri arasında anlamlı ve pozitif bir ilişki bulunmaktadır. Genel olarak, tükenmişlik düzeyleri iki boyutta incelenmiştir. Bunlar; duygusal tatminsizlik ve davranışsal yabancılaşmadır. Belirtilen tükenmişlik düzeylerine üzerine etki eden mobbing davranışları sadece "şefinin yıldırma davranışları" boyutundan oluşmaktadır. Bununla birlikte, mobbing davranışları ile bu değişkenler arasında anlamlı ve pozitif ilişki bulunmaktadır. Sonuç olarak, "şefinin yıldırma davranışları" boyutu asistan hekimlerin genel olarak tükenmişliğini artıran, ayrıca her bir boyutta anlamlı bir sebep olarak görülmektedir. Ayrıca, mobbinge maruz kalan kişilerin tükenmişlik seviyeleri artmakta ve bu süreci yaşayan katılımcıların iyilik hali durumları mobbing ile tükenmişliğin arasındaki etkileşim tarafından anlamlı olarak olarak etkilenmektedir.

Anahtar Kelimeler: Sağlık sektörü, asistan hekim, mobbing, şefin yıldırma davranışları, duygusal tatminsizlik, davranışsal yabancılaşma.

CHAPTER 1

INTRODUCTION

In business life, we observe systematical and regular hostile, aggressive behaviours, and attitudes towards to an individual or group that last for at least six months (Sürgevil, Fettahlıoğlu, Gücenmez, Budak, & Budak, 2007). This phenomenon is named "mobbing" in English and translated to Turkish as intimidation, emotional attack and psychological violence. These behaviours can directly affect the psychological well-being and work behaviours of the employees and the performance of the enterprises. Burnout is a phenomenon that usually follows mobbing and reduces the quality of business life and negatively affects employee health (Sürgevil, Fettahlıoğlu, Gücenmez, Budak, & Budak, 2007). Burnout appears to be a severe threat to both individuals and businesses (Arı & Bal, 2007). The International Labor Organization (ILO) reports that the adverse psychological issues such as mobbing and burnout in workplaces are increasing in recent years on a global scale (Dikmetaş, Top, & Ergin, 2011).

Physicians usually cope with high levels of stress in daily work. As a result of stress, mental illness, substance abuse, loss of functionality, and suicide risk can increase. Medicine is a stressful profession due to the responsibility to save the patient and the feeling of frustration due to the potential deterioration of the progress (Mccue, 1982; Meier, 2001). The emotional stressors create strain for physicians. As a result of this situation, the doctor-patient relationship is negatively affected. Physicians tend to argue over time and become intolerant to those around them (Myers, 2008). The profession of medicine is described by ILO as a stressful profession with an intense workload under the influence of many negative factors arising from the working environment (Arigoni, Bovier, & Sappino, 2010).

Burnout is defined as a syndrome that manifests itself in the professions that have generally face to face interaction with people in business life (Ishak et al., 2009). They become gradually insensitive because of their overwhelming interpersonal communication who expect service, they find themselves in emotionally exhausting states and experience a decrease in their sense of personal

accomplishment and competence (Maslach & Jackson, 1981). Also, long working hours and shift working conditions are the most important reasons for the development of burnout (Ntantana et al., 2017). Physicians, following their medical school education, are appointed to specialization career path to participate in education, training, and research as a research assistant doctor or assistant physicians in Turkey. During medical school, the bottom-up relationship has an important place. The assistant physicians, who are at the lower level of this hierarchy, are assigned more in the night and weekend shifts, and their working hours are longer. For these reasons, the risk of burnout increases for assistant physicians.

Mobbing and burnout concepts, which are a phenomenon that can be encountered in almost every workplace today, are sources of stress that harm the individuals in working life. Persecutors, practising psychological harassment, show the actions which include nicknaming, humiliating, excluding, gossiping, and aggressiveness towards their victims. This kind of psychological harassment encountered in working life was named “Mobbing” in Scandinavian countries for the first time (Palaz, 2016).

Studies on the mobbing have been gaining momentum, especially since the beginning of the 2000s. Mobbing can occur more often in the education sector (Cemaloğlu & Kılınç, 2012; Farrington, 2010; Uğurlu, Çağlar & Güneş, 2012), in the health sector (Dikmetaş, Top & Ergin, 2011; Tengilimoğlu & Mansur, 2009), and also in the banking sector (Karcıoğlu & Çelik, 2012; Kök, 2006). Heavy workload, lack of safety, control, changes in technology, adverse physical conditions of the workplace, lack of feedback and social support, and lack of open communication within the organization trigger the burnout in addition to mobbing in the workplace (Sürgevil Dalkılıç, 2014).

The damage caused by mobbing behaviour to assistant physicians does not only affect their work-life; psychological problems such as burnout are reflected in their private lives. Situations caused by mobbing can prevent assistant physicians from continuing to work in the same workplace and make it difficult for them to return to working experience. Physicians, who offer positive gains to individuals

physically and mentally, are among the primary reasons to be happy in the health sector, which has a significant place for humanity, and to maintain a better quality of life. In this context, it is a necessity to eliminate harmful conditions that will create strain for physicians.

The current research aims to investigate the effects of mobbing behaviours on assistant physicians' burnout levels. The studies of mobbing and burnout on assistant physicians in the health sector are limited. This study aims to contribute to the existing literature by determining the effect of exposure to mobbing on burnout levels of assistant physicians working in hospitals.

CHAPTER 2

LITERATURE REVIEW

2.1. MOBBING

2.1.1. Definition and Historical Development of Mobbing Concept

The word of mobbing, which has a meaning like unstable crowds and violent communities, derives from the Latin word “mobile vulgus”. The verb “Mob” in the English means gathering in one place, attacking and disturbing. In many languages, this term is used as “Mobbing” without translation. The reason for this is the difficulty of finding the exact equivalent of the term (Çobanoğlu, 2005).

In the early 1980s, German psychologist and medical scientist Dr Heinz Leymann pioneered to describe the concept of mobbing in the workplace. In 1984, Leymann introduced the concept of mobbing in business life for the first time in a report on “Safe and Health in Business Life” in Sweden. Leymann (1996) defined it as a systematic psychological terror, accompanied by unethical behaviour by one or more people at least once a week and for six months (Ekici, Yıldırım, & Timuçin, 2007; Leymann, 1996). Besides, Leymann carried out comprehensive studies by using the concept of mobbing to describe the disturbing, aggressiveness, and irritating behaviours (Aydın & Özkul, 2007).

When the literature is examined, many definitions have been made regarding the concept of mobbing. The World Health Organization (WHO) defines mobbing as attitudes and behaviours that harm the physical, spiritual, moral, and social development of individuals or groups by using force against them (Tutar, 2014). The International Labor Organization (ILO) defines mobbing as a form of psychological harassment that involves brutal attitudes, injustice and negative criticism, exclusion from the social environment in the workplace, making humiliation and unfounded rumours and also the aim of torture (Ulusoy, 2013). Hoel and Cooper (2000) defined this concept as workplace bullying. It was explained as the continuous exposure of one or more individuals to negative behaviours within a specified period. Salin (2006) clarified the concept as

workplace bullying that is repetitive and ongoing negative behaviour directed towards one or more people, reflecting a visible power inequality and creating a hostile environment in the workplace.

The terms and definitions used by other authors who examined the mobbing concept in the literature and carried out their studies are as in Table 2.1 below.

Table 2.1. Definitions Used in the Literature on the Concept of Mobbing

Author	Term	Definition
Brodsky (1976)	*Harassment*	Repeated and persistent attempts by a person to torment, wear down, frustrate, or get a reaction from another person; it is the treatment which persistently provokes, pressures, frightens, intimidates or otherwise cause discomfort in another person
Thylefors (1987)	*Scapegoating*	One or more people who during a period are exposed to repeated, negative actions from one or more other individuals
Matthiesen, Raknes, & Rrökkum (1989)	*Mobbing*	One or more person's repeated and enduring adverse reactions and conducts targeted at one or more persons of their workgroup.
Leymann (1990)	*Mobbing / Psychological Terror*	Hostile and unethical communication that is directed systematically by one or more persons, mainly towards one targeted individual.
Kile (1990a)	*Health endangering leadership*	Continuous humiliating and harassing acts of long duration conducted by a superior and expressed overtly or covertly.
Wilson (1991)	*Workplace Trauma*	The actual disintegration of an employee's fundamental self, resulting from an employer's or supervisor's perceived or real continual and deliberate malicious treatment.

Ashforth (1994)	*Petty tyranny*	A leader who lords his power over others through arbitrariness and self-aggrandizement, the belittling of subordinates, showing lack of consideration, using a forcing style of conflict resolution, discoursing initiative and the use of non-contingent punishment.
Vartia (1993)	*Harassment*	Situations where a person is exposed repeatedly and over time to negative actions on the part of one or more persons.
Björkvist, Österman and Hjetback (1994)	*Harassment*	Repeated activities, to bring mental (but sometimes also physical) pain, and directed towards one or more individual who, for one reason or another, are not able to defend themselves.
Adams (1992b)	*Bullying*	Persistent criticism and personal abuse in public or private, which humiliates and demeans a person.

Source: (Einarsen, 2000)

Some of the other terms are psychological intimidation, psychological violence, oppression, psychological terror, siege, bullying, harassment, and distress. This concept is also called workplace bullying in more contemporary sources (Gül, 2009; Tınaz, Bayram, & Ergin, 2008). Although there are differences between the dictionary meanings of mobbing and workplace bullying, it is seen that these concepts are used interchangeably and intertwined in international studies (Hoel, Zapf, & Cooper, 2002). However, Leymann stated that the term bullying is appropriate for the use of psychological violence in schools, and the term mobbing is suitable in organizations and workplaces (Özdemir & Açıkgöz, 2007).

Bullying is mostly used to express the phenomenon that examines grouping among students and their behaviours in schools. Both mobbing and bullying include psychological and physical violence applied to the person. However, in the term of bullying, there is physical violence as well as psychological violence. Psychological violence is more prevalent in the concept of mobbing (Gün, 2009). While bullying

is rude behaviour, mobbing is applied as any kind of humiliating attitude and behaviour. Physical violence is rarely encountered in the case of mobbing.

Another term to differentiate from mobbing is the conflict. Conflict is a disagreement arising from various sources between two or more people or groups (Hatch, 1997). It is a situation that occurs as a result of tension caused by troubles that prevent the fulfilment of physiological or social-psychological needs. The differentiation of the suggestions is among the causes of conflicts (Darling & Walker, 2001). Because of the difficulties that prevent the satisfaction of their socio-psychological needs, they experience tensions, because individuals have different goals. A person's goals and values may contradict others' goals and values (Eren, 2001). The most crucial difference between the concepts of conflict and mobbing is not "what happened" or "how it happened". These are the psychological and pathological outcomes that occur clearly with the frequency, duration, and effects of the events (Tınaz, 2006). Mobbing is a different concept from the conflict in terms of two main features. Mobbing contains unethical behaviours, and it has negative contributions effect on the organization (Cassitto et al., 2003). Conflict at a certain level helps contribute, improve performance, and learn from the process, which is the primary element of everyday life. Conflict is considered normal and even useful. However, workplace mobbing is devastating for business because it is immoral and causes harm. Conflict in a healthy competition situation can be resolved, but when it comes to a mobbing, it is challenging to clear up.

Furthermore, in the mobbing process, some parties take part. There are three types of participants in their actions. Each of these three groups has its characteristics and effectiveness, as well as being affected by each other. These groups are victims, persecutors, and bystanders. The risk of being a victim is viable to everyone. The persecutors generally consist of people such as managers, chiefs, and bosses. The bystanders are witnessing the mobbing process (Güngör, 2008; Tınaz et al., 2008).

2.1.2. Stages of the Mobbing Process

Mobbing is a process consisting of several stages. Recognizing the symptoms that point to mobbing is of great importance in this process. As time goes on, each step brings more severe conditions than the previous one. In the mobbing process, Leymann identifies five stages (Davenport et al., 2003):

Stage-1: At this stage, it becomes a situation with the emergence of a triggering critical event. The current situation is not a mobbing, but any behaviour displayed may turn into mobbing in a short time (Leymann, 1996). The victim does not have any physiological or psychological discomfort yet. It should be in the criteria of determining whether it will turn into mobbing.

Stage-2: Aggressive actions and psychological pressures show that mobbing dynamics are taking action. Aggressive behaviours towards the person have begun. The victim is harassed and continuously subjected to rude behaviour (Gates, 2004a).

Stage-3: If management is not directly involved in the second phase of the process, it may approach the situation with prejudice by misjudging the previous one. In this way, it gets involved in the negative cycle. If the management cannot thoroughly investigate and understand the incidents, it may find the victim guilty as a result of misunderstandings (Leymann, 1996). Especially if there is an audience that supports mobbing, they can put the victim in an unwanted position against the administration. They may even mislead management and show they have made mistakes that the victim has not done.

Stage-4: This stage is essential because victims are stigmatized as “difficult person’, “paranoid personality” or “mentally ill”. This situation reveals a negative cycle. The wrong judgment of management and the diagnosis of health professionals accelerate this cycle. At the end of this phase, there is often dismissal or forced resignation. If the person tries to get psychological support at this stage, the employees in the workplace who realize this situation can use this process against the victim. The victim can start to progress towards the lousy end, even if they are granted long sick leave for the support and assistance they receive (Leymann, 1996).

Stage-5: As a result of not believing or believing in the person after being removed from the workplace, the emotional tension that the person experiences and the psychosomatic diseases that follow them continue and intensify (Davenport et al., 2003). After the mobbing process, the person who is removed from the workplace has Post Traumatic Stress Disorder (PTSD).

The mobbing process at workplaces in many European countries is investigated from the perspective of Leymann's model. However, the stages of mobbing may vary depending on the cultural differences of the nations. In addition to the Northern European countries model, there is also an Italian-Aegean model. This model was developed by Ege (2000) and consisted of six stages (Çobanoğlu, 2005).

Zero Stage: In this stage, the victim is identified. The aim is to intimidate the victim. Conflicts cover not only business but also special situations.

First Stage: The victim starts to think about the reasons for what has been done. Persecutor's attacks do not yet cause psychosomatic symptoms, but the victim cannot give meaning to the situation and relationships. Information begins to be hidden from the victim. The excess workload is loaded, and uncertain jobs are requested for which the deadline is unknown (Cowan, 2009).

Second Stage: Psychosomatic disorders begin to be seen in the victim. The first symptoms are uncertainty and eating problems.

Third Stage: Mobbing becomes apparent, and the victim's error rate increases. Everyone is aware, but nothing is done. Health problems occurring in the victim in the previous stage cause the victim to absent due to the difficulties experienced at the workplace. Management's entitlement to persecutors leaves the person even more helpless.

Fourth Stage: Victims' psycho-physical and mental health deteriorates. The victim gets worse and gets depressed. Drug treatments and therapies have begun. The victim, who does not get support from the administration, sees that they believe that she/he is guilty.

Fifth Stage: The victim is removed from business life. It results in firing or resignation. The person can also be forced into early retirement. As a result, the victim can commit suicide.

2.1.3. The Degrees of Mobbing

In degrees of mobbing, duration, severity, frequency, and additionally, individuals' psychological structures and living conditions play a vital role (Davenport et al., 2014). Mobbing is classified in three degrees as first, second, and third-degree (Tınaz, 2011; Davenport et al., 2014).

First Degree of Mobbing: The victim tries and struggles to resist. If they can deal with struggles, they can overcome the problem in the early stages and even escape. They can save themselves without being exposed to this situation, or they may go to a new job and continue at a different place in the same workplace. Sleep problems, irritability, and concentration disorders may begin for the victim.

Second Degree of Mobbing: The victim can no longer resist. They begin to suffer temporary or prolonged mental/physical discomfort. Alcohol or drug addiction begins. They often ask for permission to escape from the workplace. The need for medical help starts at this degree.

Third Degree of Mobbing: Victims at this stage are no longer able to work and do their job. Even if the victims are treated psychologically and physiologically, they have become unable to improve. They go to work with feelings of fear and hate. Professional treatment can be beneficial because victims can harm both themselves and their environment. They face severe depression. Symptoms such as panic attacks, heart attacks, and accidents occur (Davenport et al., 2014).

2.1.4. Types of Mobbing

2.1.4.1. Top-Down Mobbing

It is the mobbing actions performed by the individuals in the upper position towards their subordinates. The superiors use their corporate power by crushing their subordinates and pushing them out of the institution (Tetik, 2010). The general characteristics of the individuals in this upper position include that they do not have

leadership qualities. Also, they are power-hungry people, and they have a lack of management ability (Toker, 2008).

2.1.4.2. Upwards Mobbing

It is a rare type of mobbing. This form of mobbing is the case of not recognizing an authority. Behaviours such as not fulfilling the tasks given, questioning the decisions taken by the manager, and looking for a continuous error are observed to exclude and sabotage the manager. This type of mobbing has different methods than other methods, such as slowing things down, deliberate mistakes, and sabotaging projects. At this point, Foucault (1976) said that this power never belongs to a specific class in the organization. Therefore, regardless of the individual's position or title, people can be victimized by anyone in the workplace (Leymann & Gustafsson, 1996).

2.1.4.3. Horizontal Mobbing / Equal or Functional Mobbing

The concept of mobbing that occurs between people who have equal status, and do the same job, is called horizontal mobbing or equals or functional mobbing. Horizontal mobbing takes place between people who have a functional relationship between them. In this type, a few people come together and apply mobbing to one person (Temizel, 2013). In this type of mobbing, the person is alienated against people in similar positions. Horizontal mobbing arises from reasons such as jealousy, competition, inability to attract (Foucault, 1976).

2.1.5. Mobbing in the Health Sector

Healthcare organizations differ in many ways compared to other organizations. Health service is carried out in harsh working environments due to long working hours, massive workloads, the salary lower than the level of labour and expertise, work conditions, and health risks arising from work. People working in the health sector are considered to have higher mobbing risk compared to other occupational groups (İlhan, Özkan, Kutcebe, & Aksakal, 2009). Mobbing in health institutions happens as verbal, physical, or behavioural attacks that health personnel or physicians are exposed to by patients, their relatives, and their superiors

(Annagür, 2010). The mobbing in health institutions reaches occupational hazard dimensions. Increasing violence and aggression makes it difficult for healthcare professionals and physicians to do their jobs. This situation is considered to be an essential public health problem for society and institutions since it directly or indirectly affects health service (İlhan et al., 2009). Many studies investigating mobbing among healthcare professionals mention that hospital environments have become dangerous for healthcare professionals day by day (Özcan, & Bilgin, 2011). It can cause problems of trust among physicians. Changes in health and gaps in legal practices are not enough to prevent mobbing (Annagür, 2010). Also, working conditions increases the size of mobbing.

The high number of patients, long working hours, discrimination between patients, lack of medical equipment and supplies in hospitals, lack of social life due to wages, bureaucratic obstacles, occupation failure to fulfil the requirements can be counted as a trigger factor for mobbing in the health sector (Çobanoğlu, 2005; Dikmetaş et al., 2011). The spread of violence and the increase in the number of individuals subjected to mobbing also brings with it several negativities. In a joint report published in 2002, WHO, ILO, and the International Nurses Council (ICN) reported the level of violence against health workers in different countries. According to the results of this report, 3-17% of the health workers are exposed to physical violence, 27-67% is verbal, 10-23% are psychological, 0.7-8% are sexual, and 0.8-2.7% are ethnic violence. It has been determined that patients and their relatives usually do verbal and physical violence in health institutions in our country. In studies conducted abroad show that patients generally harass the doctor or healthcare personnel (Keser, 2006). Another finding on the subject is that female employee in health institutions experience mobbing more than male employees (Ferrinho et al., 2003). Mobbing can be seen especially for female employees, people aged 39 and under in our country (Ayrancı, Yenilmez, Günay, & Kaptanoğlu, 2002). Research shows that health workers are sixteen times more likely to be intimidated than other service sector workers, and nurses are three times more at risk than other health workers (Kingma, 2001). Mobbing is an important problem that negatively affects many nurses' retention. Surveys that conducted in

the United States in 1996, Canada in 2000, Sweden in 2000, England in 2000, and Australia in 2000 show an alarming resemblance. It reveals that mobbing is a great universal problem for nurses. O'Connel et al. (2000) in their study with 209 nurses in a large training hospital in Australia; revealed that 92% of the participants experienced verbal abuse that repeatedly occurred in the 12 months, and 80% were physically abused during the same period (Jackson, Clare, & Mannix, 2002). Hegney et al. (2003) cited that nurses were exposed to mobbing than other healthcare workers. They stated that nurses with less than ten years of work experience are at great risk. It was determined that 38% of the nurses in the UK suffered intimidation, and 42% of them were disturbed by other staff (Agervold, 2007). The conclusions drawn from the studies in Turkey have also mentioned that the concept of mobbing is one of the areas broadly experiencing the health sector. Bilgel et al. (2006) researched white-collar employees in the health and education sectors and law enforcement agencies in Bursa. In their study, 55% of the employees were exposed to mobbing, and health sector workers were at the most risk (Kırel, 2007). Mobbing in Turkey is increasing research on the subject, although a new concept compared to other countries. Several studies on the field of health reveal the dimensions of mobbing in our country. In research conducted by Özdevecioğlu on nurses in 2003, showed that 89.5% of nurses were exposed to mobbing. In the study conducted by Dilman in 2007, the rate of exposure to mobbing was determined as 70%. In another study conducted by Aksoy in 2008, the level of health workers' effectiveness due to mobbing was examined. It was concluded that mobbing caused 39.6% work and effort reduction. In a study examining the effects of mobbing on healthcare workers in Isparta, it was stated that they were exposed to mobbing by the manager, directly linked to 41.2%, and 11.2% of the verbal complaint (Salin, 2001). In Turan's (2006) study involving doctors, nurses, and technicians, it is seen that the participants in the research think that they are mostly exposed to mobbing due to envy. Rare causes of mobbing are belief, age, political view, and marital status. Sharing the situation with friends and ignoring are the most frequent reactions of employees exposed to mobbing. The most frequent mobbing are aggressive behaviours in the dimensions of

communication and their impact on the quality of life and work. As a result of the research carried out by Solakoğlu (2007) shows that the health workers participating in the study from a public hospital in Eskişehir were victims of mobbing by 38.6%. According to the research conducted by Kaymaz (2007) on health workers, when doctors encounter mobbing behaviour, they tend to speak to the mobber and clarify the incident. They apply to a higher official if they cannot find a solution. Çöl (2008) shows that the prevalence rate of mobbing in hospitals was found to be 34.9%. Almost every third person working in the hospital is exposed to mobbing directed by a friend or supervisor. In Aksoy's study on 250 female and 162 male health workers (2008), mobbing at work and moral dimensions ranged from 12% to 60%, and verbal abuse was 31.8%, and sexual harassment was 12.4%. While sexual harassment is never seen over the age of 40, it is more common in divorced and separated people. Aytaç (2008) In a study performed on mobbing in the workplace in Turkey, emphasized that the limited number of studies done. Also, there is no legal regulation yet. In general, the health sector is one of the areas where psychological intimidation is widespread in our country. Some of the factors related that cause mobbing in the health sector are listed as follows (Çobanoğlu 2005).

a) Medical facilities in hospitals are very insufficient,
b) The intensity of the working tempo due to the high number of patients,
c) Inadequate salaries,
d) A large number of bureaucratic obstacles,
e) Discrimination during academic career and promotion,
f) Difficulty in family life due to intensive working conditions and intensity of nights and weekend shifts,
g) The requirements of the profession are not entirely fulfilled,
h) Discrimination among patients based on status and economic situation,
i) Discrimination is made due to the proximity to the administration and personal approach to the manager.

The research mentioned above shows the dimensions of mobbing in the health sector. It reveals that managers should pay more attention to this issue.

Considering that the segment served is human, the importance of healthcare professionals to perform profession is increasing. Employees providing services in a healthcare facility without mobbing will work more efficiently and bring their job satisfaction and patient satisfaction. Therefore, mobbing prevention policies should be adopted and implemented by managers. The concept of mobbing is a serious occupational health and safety risk, which is seen intensively in the health sector and requires measures to be taken for health professionals. Mobbing in the health sector affects community health as well as the victim. For this purpose, workplace violence prevention, stress and anger management, and conflict resolution skills should be developed, and legal measures should be taken for healthcare professionals. The consequences at the individual, organizational, and social levels need to be identified (Çöl, 2008).

2.1.5.1. Mobbing Among Assistant Physicians

Assistant physicians are a risky group in terms of exposure to mobbing. Usually following work conditions create strain for assistant physicians: intense work pace, long working hours (usually more than 45 hours a week) with nights and weekend shifts, frequent rotation in different units, low quality and short sleep durations, insufficient resting times. Besides, being perceived as an intern and trainee, dealing with tasks that can be considered monotonous, very easy and meaningless are stressful for assistant physicians (Aslan, Gürkan, Alparslan, & Ünal, 1996). Akbulut et al. (2010) studies show that physicians with managerial roles has higher job satisfaction. Another study showed that the physicians advanced in their profession, who have completed their specialization degree, are married, have children, and who are socially active, are less likely to experience mobbing. The young, newly graduated, single assistant physicians are more likely to expose to mobbing (Aslan et al., 1996). Besides, Oğuzberk and Aydın (2008) reported that physicians who do not have active social life tend to use substances due to high workload. Dikmetaş et al. (2011) found that assistant physicians exposed to mobbing, experience burnout. Kokalan and Tigrel (2014) particularly

reported that assistant physicians are subjected to “not talking”, “mimics”, “gossip” and “unfair judgments’.

2.2. BURNOUT SYNDROME

2.2.1. Definition and Historical Development of Burnout Concept

Burnout is derived from the word “burnout” in English as its origin, which means that the candle burns and consumes its fire. This metaphor manifests the discharge of energy and loss of power. This metaphor explains the depletion of employees’ capacity to maintain intense participation with a meaningful impact at work (Schaufeli, Leiter, & Maslach, 2009). It is noteworthy that the importance of burnout as a social problem was determined long before it became the focus of a systematic study by both practitioners and social commentators (Maslach, Schaufeli, & Leiter, 2001). The productive capacities of individuals experiencing burnout will decrease.

Burnout syndrome is a concept that was first introduced by Freudenberger in 1974 to describe the fatigue, disappointment, and tendency to quit among health workers (Freudenberger, 1974). Freudenberger found that most of the volunteers had been working with enthusiasm for about a year, but then suddenly quit their jobs. Many of these volunteers used the term “burnout” to describe the mixed feelings they experience, such as disability, pessimism, and depression (Yılmaz & Turan, 2007). Shortly after that, social psychologist Christina Maslach conducted a series of studies for the first time in 1976 to explain and measure this concept (Ergin, 1992). Maslach defined burnout concept as a syndrome characterized by emotional exhaustion, depersonalization, and personal accomplishment. She has formed the basis for academic studies in this field with the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). Emotional exhaustion appears first in the development of the concept of burnout. It begins to get tired of work and unable to find the mental strength necessary for work. Following emotional exhaustion, depersonalization develops, and employees treat the people they serve as objects rather than people. Following the depersonalization phase, a decrease in personal accomplishment, which is the last stage of burnout, develops (Maslach & Jackson,

1986). Also, Maslach worked mainly on healthcare professionals and recognized that burnout is a new psychological state (Schaufeli & Enzmann, 1998).

Burnout is a problem, especially for professional groups dealing with people. In the middle of the 1980s, researchers began to realize that burnout did not occur only in occupational groups serving people (Maslach & Leiter, 2016). For example, managers, engineers, and other workers from different professional groups could also face this situation. Therefore, the definition of burnout expanded. On the other hand, Pines, Aronson, and Kafry (1982) presented a slightly broader definition of burnout without limiting their ideas to employees alone. They defined burnout as "a state of physical, emotional, and mental fatigue caused by a long-term relationship in emotionally demanding situations" (p. 15). However, today the most widely accepted definition belongs to Maslach explained this phenomenon as physical exhaustion, long-term fatigue, despair, and hopelessness feelings in people who are exposed to intense emotional demands by work. It is a syndrome that is reflected in negative attitudes towards work, life, and other people (Maslach & Jackson, 1981).

2.2.2. Models of the Burnout Syndrome

2.2.2.1. Maslach Burnout Model

It is the most common burnout model accepted today. This idea that Maslach has brought up defends the three-dimensional model. These three dimensions are called "depersonalization", "emotional exhaustion" and "low personal accomplishment" (Maslach, 1978). Individuals become insensitive to people with whom they have a dialogue, emotionally exhausting, a decrease in their sense of personal accomplishment and competence (Maslach & Jackson, 1986). According to this model, "Maslach Burnout Inventory" consisting of 22 items was developed to measure burnout (Maslach & Jackson, 1986).

a) Emotional exhaustion: The depletion of emotional resources is expressed as the inability of employees to psychologically give themselves to their jobs (Maslach & Jackson, 1981). Maslach (2003) states that the consequences of the person's emotional burdens,

emotional demands of others, and being unable to go further are the results with emotional exhaustion. The person feels that they are insufficient to meet the requests of others and try to cope with their emotional burnout by reducing their professional efforts and keeping their communication with other people to a minimum sufficient to keep things going (Hamann & Gordon, 2000). According to Maslach et al. (1981), emotional exhaustion is not only a symptom but also an effort to distance themselves from the work they have developed to cope with the heavy workload. In parallel with this finding, Gabbe et al. (2002) stated that emotional burnout is also high in workers with a high workload. When the burden of physicians is higher, their burnout is increasing (Gabbe, Melville, Mandel, & Walker, 2002; Mcmanus, Jonvik, Richards, & Paice, 2011).

b) Depersonalization: In the early stages of desensitization, employees tend to do everything expected in the most appropriate way to reduce their emotional tension. This tendency becomes more insensitive over time. It has been displaced by emotion, not considering people and their needs. They are perceived as objects rather than as individuals. With the deepening of insensitivity, the individuals will tend to evaluate themselves as a cold person and indifferent person who avoids responding to others' wishes (Hamann & Gordon, 2000). Individuals can take this attitude towards their colleagues and the organization. Besides, endless chats with friends, prolonging breaks, unnecessary use of professional jargon are expressed as symptoms of depersonalization (Cordes & Dougherty, 1993).

c) Low Personal Accomplishment: It can be defined as the tendency to evaluate one's negatively (Cordes & Dougherty, 1993). It occurs as a result of the person feeling that they cannot help them when needed. Professional competence starts to be questioned as a result of feeling professionally worthless and seeing that their contributions and roles are insignificant.

2.2.2.2. Edelwich and Brodsky Burnout Model

According to this model, excessive work intensity, high working times, inadequate appreciation, low wages, expectations from work, and the current situation, bureaucratic difficulties can be counted among the causes of burnout. (Pines, Aronson, & Kafry, 1982). Also, according to Edelwich and Brodsky, burnout syndrome is more in individuals working in the service sector or professional groups working for the benefit of people. Long working hours, low wages, low education levels, dissatisfied customer density, massive workload, and especially mobbing can be counted as reasons (Ardıç & Polatcı, 2009). Edelwich and Brodsky (1980) have suggested that burnout is a process that occurs after four consecutive stages (Edelwich & Brodsky, 1980).

Stage-1: Enthusiasm: Increases in energy, excessive hope, and exaggerated professional expectations are counted. The signs of danger at this period can be listed as follows: not empathizing with the clients, spending energy for unnecessary tasks, seeing the business life as the most crucial dimension of life, the hope that the business will provide everything. At this stage, the prospect is at the highest level since the employee has challenging goals and expectations regarding the work.

Stage-2: Stagnation: In this phase, there is a decrease in demand and hope. The person starts to feel uncomfortable with the difficulties. When things do not go as planned, the person begins to get bogged down in details. The first two phases of burnout are like two opposite situations.

Stage-3: Frustration: The individuals start to question their duties, the task of the job, their meaning, and the worth of outcomes. As long as this frustration continues, the person can proceed in three paths. They may use using adaptive defence mechanisms to get out of burnout. The person using the maladaptive defence mechanisms prefers to ignore the problem and give themselves more to work.

Stage-4: Apathy: At this stage, the characteristic symptoms of depersonalization are behaviours such as emotional disruption, complete loss of work-related beliefs, despair, and to try to shorten the duration of meeting with the

clients. A recklessness and humiliation occur over time. From the other's perspective, these people are strict, cold, and uninterested in events**.**

2.2.2.3. Pearlman and Hartman Burnout Model

Pearlman and Hartman made a definition that includes all the comprehensive parameters. Their burnout model consists of three components (Meier & Toward, 1983; Tunçay, 2009), burnout is defined as a "three-component response to long-term emotional stress" (Pearlman & Hartman, 1982, p. 285): ((a) physiological dimension including physical symptoms; (b) emotional-cognitive dimension focusing on attitudes and emotions; (c) behavioural dimension focusing on symptomatic behaviours).

2.2.3. Symptoms of Burnout Syndrome

Burnout is a situation in which subjectively experienced emotional demands arise from working for a long time, accompanied by symptoms such as helplessness, hopelessness, frustration, development of a negative self-concept, development of negative attitudes towards work, workplace, employees, and life (Demirtaş & Güneş, 2002). Burnout syndrome is not a sudden occurrence, but rather a slow and insidious cluster of symptoms. Ignoring the burnout symptoms also causes it to progress and become insurmountable. For this reason, it is imperative to know the signs of the insidious process of burnout and to take necessary measures by identifying them in time. Burnout symptoms vary from person to person but generally include physical and psychological symptoms.

2.2.3.1. Physical Symptoms

Individuals who experience burnout, perform successfully at the beginning of their professional life, who are skilful, self-confident, energetic, and enthusiastic about work, which prolongs despite fatigue and insufficient sleep durations. However, over the years, work performance decreases and reduces the energy of individuals, and various physiological symptoms emerge. They are; weakness, loss of power, decrease in energy, fatigue, decreased resistance of the body to diseases, headaches, cramps, sleep disturbance, insomnia constipation, muscle tension low

back, pain, and gastrointestinal complaints (Moss, Good, Gozal, Kleinpell, & Sessler, 2016). Individuals may not realize that these are caused by burnout. They attribute this to fatigue or sickness (Aslan, Kiper, Karaağaoğlu, Topal, Güdük, & Cengiz, 2005).

2.2.3.2. Psychological Symptoms

If the individuals have lost control of the job or lack the resources, it makes it impossible to overcome the obstacles on the career path. Besides, if the individuals cannot get the rewards, it will not be surprising that they feel inadequate. As a result of the time and effort spent, the individual may feel exhausted (Dinç, 2008). The individual's nervousness will trigger adverse reactions to people and desensitization towards work. For these adverse reactions, the individuals will begin to blame others for their problems, and their response will be more punitive and aggressive. However, frustrated individuals will be stricter about the way of job and will close themselves to new alternatives (Yüksel, 2011). Emotional symptoms are: emotional exhaustion, a chronic state of nervousness, anger, difficulties in cognitive skills, frustration, depressed emotional state, anxiety, restlessness, impatience, low self-esteem, worthlessness, hypersensitivity to criticism, the inability of decision making, apathy, emptiness and hopelessness (Kaçmaz, 2005).

2.2.4. Burnout Syndrome in the Health Sector

The rate of burnout is higher in professions such as doctors, nurses, dentists, teachers, police officers, psychologists, lawyers that require frequent face to face interaction with people (Ishak, Lederer, Mandili, Nikravesh, Seligman, Vasa, & Bernstein, 2009). Health professionals, such as physicians and nurses, who are in professional groups with high levels of devotion for others, are exposed to physical and mental fatigue (Wright & Cropanzano, 1998).

High workload and stress at work are important factors that increase burnout in healthcare workers (Aslan & Özata, 2008). Health services differ from other services in terms of their quality. Health is a fundamental human right earned at birth. International agreements and declarations also accepted this situation. In this

context, health services have the most basic service feature required for the development of health and human qualities. It requires more effort to meet more attention, empathy, and expectations during service. Providing competent service leads to health workers' emotional burnout. This effort for a long time and with intensity increases exhaustion. In environments with unfavourable work conditions, the quality of the service deteriorates, and burnout may occur (Çam, 1995). Insufficient conditions in the working environment, intense working hours, concerns about a professional career, lack of necessary support from the family life affect the health and social life of the physician, and in this case, weakening of satisfaction from work prepares the ground for the formation of burnout syndrome (Çan, Topbaş, Yavuzyılmaz, Çan, & Özgün, 2006). In particular, doctors and nurses cannot correctly maintain their mental health in these situations (Taycan, Kutlu, Çimen, & Aydın, 2006).

Also, in this literature review area, significant differences have been reported in the prevalence of burnout syndrome in healthcare professionals in the healthcare sector, among doctors (Ramirez, Graham, Richards, Gregory, & Cull, 1996) and nurses (Lu, While, & Barriball, 2005). However, a higher level of severe burnout syndrome is observed in oncologists (Lyckholm, 2001), and anaesthetists (Nyssen, Hansez, Baele, Lamy, & Keyser, 2003) and doctors working in emergency departments (Weibel, Gabrion, Aussedat, & Kreutz, 2003).

In a study on assistant physicians, the burnout level of the young, single and child-free assistant doctors was high. The burnout level was found to be low in married, advanced age, and physicians with a child. In this study, the reason for this was explained as the fact that young doctors have not gained experience yet, and that they cannot benefit from social, family support for single people (Aslan, Gürkan, Alparslan, & Ünal, 1996). In another study on burnout levels of doctors and nurses, gender, age, and working time do not affect burnout. Emotional exhaustion increases in people who choose their profession voluntarily and who want to change their occupation. Nurses were found to experience more emotional exhaustion than physicians (Haran, Sayıl, Ölmez, & Özgüven, 1998). In the research published in 2010, Altay et al. found the emotional exhaustion and

depersonalization sub-dimension in physicians because of long nights and weekend shifts, long hours of work, and less time to sleep (Altay, Gönener, & Demirkıran, 2010). Another study found to be high in emotional exhaustion and personal success in specialist physicians. Also, other reasons for high burnout among doctors were found to be uncertain, high responsibilities at work, and inadequate physical conditions at work (Kurçer, 2005).

Besides, workplace climate and workload have been accepted in the studies conducted as the most important determinants of this situation. (Mcmanus, Keeling, & Paice, 2004). The physician's dissatisfaction with the profession is also a factor that affects burnout (Aktuğ, Susur, Keskin, Balcı, & Seber, 2006). Burnout syndrome brings professional problems to physicians. The burnout seen in the physicians giving treatment affects the treatment quality, patient satisfaction, and patient safety negatively (Firth-Cozens & Greenhalgh, 1997). The physicians begin to show less interest in their patients. Besides, it has been shown in many studies that physicians with high levels of burnout make more medical errors (Maslach et al., 2001; Shanafelt et al., 2011). Burnout syndrome becomes significant with malpractice cases arising from these errors (Balch et al., 2011).

For these reasons, in physicians with burnout syndrome, thinking of changing jobs occurs, and absenteeism increases. Especially in assistant physicians, intention for changing departments occurs. The importance and effort have given by physicians decreases, and also the work efficiency decreases (Maslach, 1978). The decline of the individual and professional achievements of physicians also reduces the success of the institution. Physicians face emotional tension and begin to communicate with people as little as possible. As they communicate less, it can result in insufficient attention to patients. Exhausted physicians often come into conflict with their colleagues. Also, job satisfaction and commitment decrease as a result of burnout (Maslach & Leiter, 2014). Problems occur in private life as a result of tension due to the negative consequences of burnout about work. Family members are directly affected by the difficulties experienced by the individual. The increase in divorce rates today; strengthens the assumption that employees

compromise their family lives to succeed in their work. In other words, success in business takes place at the expense of family peace (Önal, 2006).

In summary, physicians and healthcare workers face the risk of burnout, and this negatively affects health services (Spickard, 2002). Burnout syndrome in physicians is closely related to deterioration in work and social relations, alcoholism, and increased risk of suicide (Gabbard, Menniger, & Coyne, 1987; Shanafelt et al., 2011).

2.2.4.1. Burnout Syndrome in Assistant Physicians

The first signs of burnout in the form of fatigue and emotional exhaustion usually emerge among physicians during the medical school years or the period of the assistantship. These may cause deterioration in mental health (Hsy & Marshall, 1987; Musal, Elçi, & Ergin, 1995). The burnout syndrome gets intense in the physicians mainly due to the intensive training in specific branches after medical education, a large number of shifts and intense demand, and heavy workload in clinics and polyclinics. There is no doubt that the quality of the services to be provided in an institution will be much higher. Physicians who started to work as assistants in our country are faced with a massive workload, long working hours, and a high rate of night and weekend shifts. Also, these individuals who experience burnout bring emotional exhaustion with physical symptoms. The cause of physical symptoms and fatigue is mainly a feeling of tension. The passion for the job decreases among assistants. Those who are at the beginning of their career see their jobs as a challenge. Prolonged tension and feeling of fatigue increase the probability of suffering from illnesses such as influenza and psychosomatic complaints (Maslach et al., 2001). Assistant physicians develop specific skills in their chosen field of medicine to maintain the quality of patient care. During this period, they suffer from sleep deprivation, high workload, and unsatisfactory salary (Wallece et al., 2009), and workload. This combination of factors renders them vulnerable to the development of burnout (Embriaco et al., 2007; Sürgevil et al., 2007). It leads to intervention in the individual's ability to work with diagnostic dilemmas and complex treatment decision making (Ergin, 1992). Studies have shown that

assistant physicians may experience adverse mental health and work performance with the high prevalence of the syndrome (Sürgevil, 2006).

2.2.5. Relationship Between Mobbing and Burnout

The six factors that lead to burnout of employees were defined by Maslach and Leiter (1997). These are excessive workload, excessive control and pressure, inability to appreciate, unequal social relations, lack of justice and respect, and incompatibility of values with the business. In the case of mobbing, almost all of these factors exist. In case of prolonged mobbing, the individual feels depleted (Minibaş-Poussard, & İdiğ-Çamuroğlu, 2009). Izquierro et al. (2006) examined psychological variables related to mobbing with the participation of 520 employees from the health and education sector. Their study aimed to determine the variables that can differentiate the groups exposed to high and low mobbing risk. Study results showed that there are relevant links between mobbing and variables (burnout, job satisfaction, and psychological health). Through discriminant analysis, it has been found that dissatisfaction with the administration, emotional exhaustion, cynicism and depressive symptoms allow individuals to identify the risks of exposure to intimidation (low or high). The research was done by Einarsen, Matthiesen and Skogstad (1998) on assistant nurses working in the health sector in Norway; their findings suggest that there is a significant and positive relationship between mobbing and burnout. Sa and Fleming (2008) examined the prevalence of mobbing behaviours against Portuguese nurses and the relationship between burnout syndrome symptoms and mental health of nurses reporting that they are exposed to mobbing. One hundred seven nurses participated in their study. It was concluded that 13% of these people had been exposed to mobbing in the last six months. They clarified that the three common mobbing behaviours that nurses face. These were doing work below their level of expertise, taking away their areas of responsibility or replacing them with less critical and wrong tasks and exposing them to more work than they can handle. Nurses who have been daunted have been adversely affected.

In the study where Dikmetaş, Top and Ergin (2011) examined the burnout and mobbing levels of assistant physicians; there is a significant relationship between mobbing and burnout. Also, there is a significant relationship between mobbing and sub-dimensions of burnout, "emotional exhaustion", "depersonalization" and "personal success". The result of their regression analysis showed that the mobbing levels of assistant physicians significantly predicted emotional exhaustion, depersonalization, and personal success. Filizöz and Alper Ay (2011) also found that the significant correlation between mobbing and general burnout was at the medium level (r= 0.48). Moreover, a significant positive correlation was found between emotional exhaustion (r=0.56) and depersonalization (r=0.58). There was no significant relationship between mobbing and personal success. Therefore, mobbing is correlated with emotional exhaustion and depersonalization sub-dimensions of burnout.

2.2.6. The Aim of the Research

In line with the literature reviews, it is seen that the employees face many adverse outcomes as a result of mobbing behaviour. It is essential to demonstrate that burnout may be one of these negative consequences or to reveal that burnout may trigger mobbing that produces such negative results. The current study aims to reveal the relationship between mobbing and burnout levels in assistant physicians who play a significant role in the health sector. This research also aims to develop new scales to investigate these constructs both from the cultural perspective of Turkey and also mainly from the context of the training/specialization process of assistant physicians.

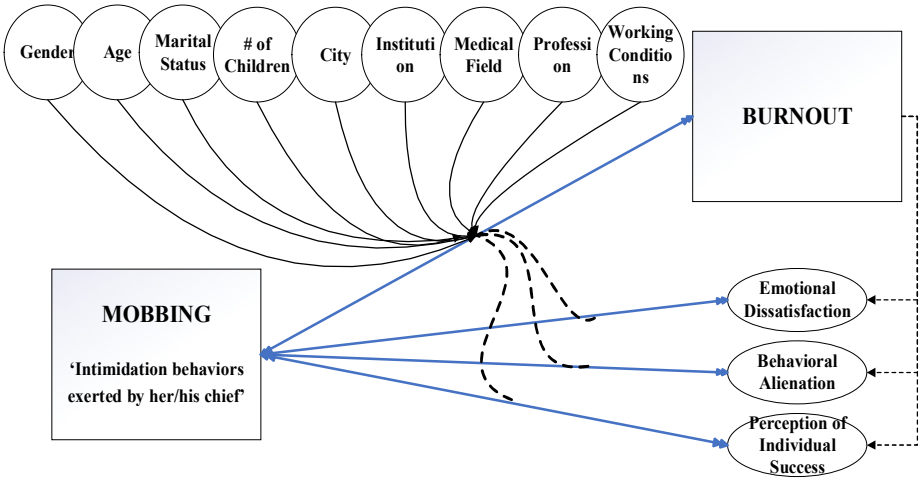
In Turkey, medical doctors are trained as a specialist in subspecialties after six years of medical school. Physicians take the exam called the Medical Specialization Examination organized by the Student Selection and Placement Center following the graduation from medical schools, and they are placed to the institutions and specialization fields according to the scores they get in that exam and their choice of area. During this process, they are entitled as a research assistant doctor or assistant physician in Turkey. Through this process, research assistants or

assistant physicians work in Public University Hospitals, Private University Hospitals, and Training and Research Hospitals for four to five years. This is the essential phase of specialist physicians' career development. Ensuring professional development is a crucial period in terms of performing medical practices following the principles and rules of medical ethics. Medical education's main base is on the relationship between senior and junior physicians. Assistant physician at the bottom of this hierarchical order, tend to be exposed to overwhelming conditions compared to other healthcare professionals such as long working hours, nights and weekend shifts, and low wages. That is why the current research took assistant physicians into the focus since the risk of health workers exposed to mobbing and burnout is higher than people who are working in other service sectors.

The current research focuses on the following issues based on the research model given in Figure 2.1.:

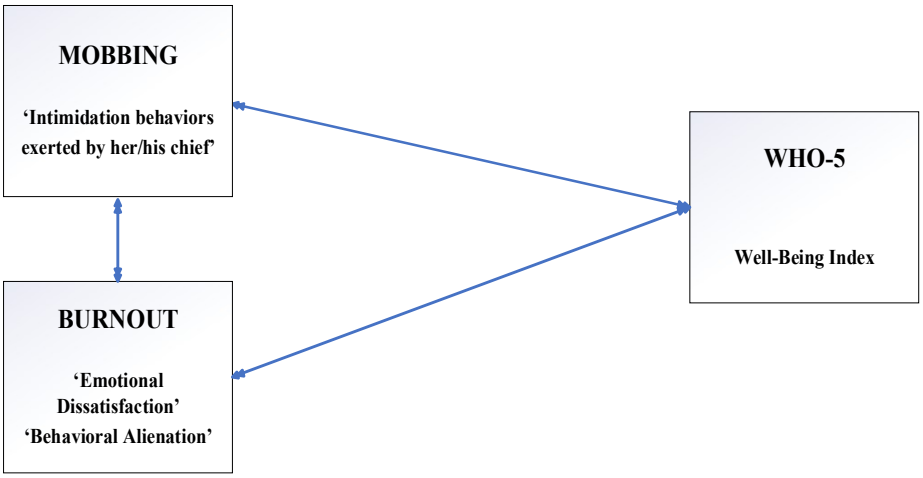
a) Developing new scales to measure mobbing and burnout specific to assistant physicians' work context and conditions.
b) Measuring the level of mobbing and burnout of assistant physicians,
c) Testing the relationships between mobbing and subdimensions of burnout,
d) Determining whether there are differences in mobbing, burnout and their sub-dimensions in terms of demographic variables,

Figure 2.1. Research Model



We also predict that as the burnout level as a consequence of mobbing increases, assistant physicians' well-being will be deteriorated. In this process, burnout is kept as a mediator for the relationship between mobbing and well-being. The relationship between mobbing and burnout would be handled as an interaction term, and the relationship between mobbing and well-being would be observed.

Figure 2.2. Research Model 2



Based on these models, the hypotheses of the research are as follows:

H_1= Mobbing and burnout levels (emotional dissatisfaction, behavioural alienation) significantly differ according to gender.

H_2= Mobbing and burnout levels (emotional dissatisfaction, behavioural alienation) significantly differ according to the medical fields.

H_3= There is a significant relationship between mobbing and well-being in the last two weeks.

H_4= There is a significant relationship between burnout levels and medical fields of assistant physicians.

H_5= There is a significant relationship between the burnout levels and well-being in the last two weeks.

H_6= There is a significant relationship between assistant physicians' exposure to mobbing and their perception of burnout (emotional dissatisfaction, behavioural alienation).

H_7= Mobbing significantly affects the burnout levels of assistant physicians.

H_8= Mobbing significantly affects the emotional dissatisfaction of assistant physicians.

H_9= Mobbing significantly affects behavioural alienation of assistant physicians.

H_{10}= The interaction between mobbing and burnout significantly affects the well-being of assistant physicians.

In the literature, different methods are used to determine the mobbing and burnout in the workplace. The studies conducted in the national and international literature on burnout and mobbing scales were examined for taking into consideration the purpose of the research. For mobbing measurement, there are scales for instance; “Leymann Inventory of Psychological Terrorization - LIPT” (Leymann, 1996; Carnero, Martinez, & Sanchez-Mangas, 2010), “Negative Acts Questionnaire - NAQ” (Einarsen & Raknes, 1997) and “Workplace Harassment Scale (WHS)” (Björkvist, Österman & Hjet-Back, 1994). For burnout measurement, “Maslach Burnout Inventory” is mainly using. In our country, the

validity and reliability analysis of “Maslach Burnout Inventory” were carried out by Çam and Ergin in 1993. It consists of twenty-two questions about emotional exhaustion, depersonalization and personal success, which are the sub-dimensions of burnout (Dikmetaş, Top, & Ergin, 2011). In this research, the questionnaires were used as a quantitative research method in collecting data. The questionnaires used in the study were tried to be developed by the researcher for thesis research.

CHAPTER 3

METHODS

3.1. Participants

The sample of the study is formed by 102 assistant physicians who are working in Public University Hospitals, Private University Hospitals, and Training and Research Hospitals. A hundred seven people attempted to fill the survey, but five responses were removed due to the missing data. Target group was contacted through the convenience sampling method [48% are (n=49) male, 52% are female (n=53)]. Educational information was not asked participants because at least six years of medical education is equivalent to a doctorate. Also, all participants are composed of assistant physicians.

As Table 3.1. shows, the majority of the physicians are at the age range of 29-31 (46.1%, n=47). While 37.3% of the participants are married (n=38), 60.8% are single (n=62), 2.0% are divorced or widowed (n=2); 85.3% of the participants do not have children (n=87).

Table 3.1. Distribution of Personal Information of Assistant Physicians

		N	%
Gender	Male	49	48.0
	Female	53	52.0
Age	22-25	6	5.9
	26-28	37	36.3
	29-31	47	46.1
	32-35	7	6.9
	>35	5	4.9
Marital Status	Single	62	60.8
	Married	38	37.3
	Divorced/Widowed	2	2.0
Number of Children	None	87	85.3
	1	9	8.8
	2	5	4.9
	3	1	1.0

Table 3.2. shows 58.8% of physicians are working in Istanbul, and the second-largest group participated from Erzurum (31.4%). The proportion of physicians working in the (Private) University Hospital is 21.6%, working in the (Public) University Hospital is 53.9%, and working in the Training and Research Hospital is 24.5%.

Table 3.2. Distribution of Assistant Physicians according to the City they Work and the Type of Hospital

		N	%
City	İstanbul	60	58.8
	Erzurum	32	31.4
	Ankara	5	4.9
	Eskişehir	3	2.9
	Bursa	1	1.0
	Van	1	1.0
Type of hospital	(Public) University Hospital	55	53.9
	Training and Research Hospital	25	24.5
	(Private) University Hospital	22	21.6

Fifty-six people (54.9%) is the medical field of internal medical sciences, and forty-six people (45.1%) is in the surgical medical sciences. Areas of speciality represent that the most considerable participation was from General Surgery (%19.6). The number of participants from Paediatrics, Child & Adolescent Psychiatry, Physical Medicine & Rehabilitation and Internal Medicine is equal (%11.8). The highest ratio of physicians graduated in 2016 (39.2%); 34.3% of the participants started their specialization training in 2018 (Table 3.3.)

Table 3.3. Distribution of Assistant Physicians according to Professional Characteristics

		N	%
Medical Field	Internal Medical Sciences	56	54.9
	Surgical Medical Sciences	46	45.1
Areas of speciality	General Surgery	20	19.6
	Physical Medicine & Rehabilitation	12	11.8
	Paediatrics	12	11.8
	Internal Medicine	12	11.8
	Child & Adolescent Psychiatry	9	8.8
	Pulmonary Medicine	5	4.9
	Emergency Medicine	5	4.9
	Obstetrics & Gynaecology	5	4.9
	Neurosurgery	5	4.9
	Public Health	3	2.9
	Medical Pathology	3	2.9
	Ophthalmology	2	2.0
	Pediatric Surgery	1	1.0
	Dermatology	1	1.0
	Cardiology	1	1.0
	Otolaryngology	1	1.0
	Neurology	1	1.0
	Orthopaedics & Traumatology	1	1.0
	Psychiatry	1	1.0
	Anesthesiology	1	1.0
	Urology	1	1.0
Graduation from medical school	2003	1	1.0
	2008	2	2.0
	2009	1	1.0
	2010	1	1.0
	2011	1	1.0
	2012	3	2.9
	2013	3	2.9
	2014	8	7.8
	2015	19	18.6
	2016	40	39.2
	2017	12	11.8
	2018	7	6.9
	2019	4	3.9

Table 3.3. (continued) Distribution of Assistant Physicians according to Professional Characteristics

		N	%
Starting year to specialization training	2010	1	1.0
	2014	3	2.9
	2015	4	3.9
	2016	13	12.7
	2017	26	25.5
	2018	35	34.3
	2019	17	16.7
	2020	3	2.9

According to working hours, 51.0% of participants (n=52) reported 9 to 11 hours per day. The other variable represents that the highest distribution was twenty-nine people (28.4%) were taking care of 61-90 patients per day. The other highest distribution is that fifty-four people (52.9%) spend 0-5 minutes allocated to the patients. Night and weekend shifts were asked to assistant physicians. Eighty-six people (84.3%) answered “Yes”, sixteen people (15.7%) answered “No”. We see that eighty-six people have night and weekend shifts because of their specialties. The other variable shows that the highest distribution was fifty-one people have (50.0%) have 6-10 night and weekend shifts per month. Although sixteen people (15.7%) who have not night and weekend shifts, they did not answer this question. Eighty-six participants responded to the question of whether night and weekend shifts were higher than the officially permitted duration an frequency. Twenty-eight people (27.5%) answered as “No” and fifty-eight (56.9%) people answered as “Yes”. The question of whether they use a day off after the night and weekend shifts were asked. Seventy-three people (71.6%) answered as “No”, eight people (7.8%) answered as “can use leave”, and five people (4.9%) answered as “the work continues until noon” (Table 3.4.)

Table 3.4. Frequency Distribution according to Workload and Work Conditions

		N	%
Working hours per day	6-8	26	25.5
	9-11	52	51.0
	12-14	13	12.7
	15-18	3	2.9
	19-24	1	1.0
	25-36	7	6.9
Number of patients per day	0-10	14	13.7
	11-20	15	14.7
	21-30	6	5.9
	31-45	4	3.9
	46-60	23	22.5
	61-90	29	28.4
	91-150	7	6.9
	151-250	2	2.0
	251-300	2	2.0
Time allocated per patient	1-5 minutes	54	5.,9
	6-10 minutes	22	21.6
	11-20 minutes	15	14.7
	21-30 minutes	7	6.9
	31-60 minutes	2	2.0
	>60 minutes	2	2.0
Night and weekend shifts	No	16	15.7
	Yes	86	84.3
Frequency of night and weekend shifts per month	1- 5	15	14.7
	6-10	51	50.0
	11 and > 11	19	18.6
Night and weekend shifts duty above the legal number	No	28	27.5
	Yes	58	56.9
Using a day off after night and weekend shifts	No	73	71.6
	Can use leave	8	7.8
	The work continues until noon	5	4.9

3.2. Measures

In this research, the questionnaires were originally developed by the researcher. It was aimed to design the survey that reflects the previous experiences and conditions of the assistant physicians and specialist physicians instead of developing a questionnaire-based only on the literature review or using the measures which were developed for other occupations and cultures.

3.2.1. Mobbing Scale

In the first part, the "Mobbing Scale" consisting of twenty-three questions designed by the researcher was used to determine the level of exposure mobbing of the assistant physicians in the research. Mobbing Scale, which was prepared to measure the mobbing level of assistant physicians includes expressions of twenty-three mobbing behaviours of the chef. In this scale, the intimidation behaviours exerted by the chief were interrgogated, and the frequency of exposure to these behaviours was measured. The scale consists of only one dimension under the name of the intimidation behaviours exerted by the chief. The scale was evaluated with a 6-point Likert-type scale, and the participant chooses one to six points as "Never" (1) and "Always".

3.2.2. Burnout Inventory

In the second part, the "Burnout Inventory" consisting of seventeen questions was designed to measure the burnout level of assistant physicians. Burnout Inventory was used to measure the burnout levels of assistant physicians. This scale was developed by the researcher to measure the three sub-dimensions of burnout: "emotional dissatisfaction", "behavioural alienation" and "perception of individual success". The scale was evaluated with a 6-point Likert-type scale, and the participant chooses one to six points as "Never" (1) and "Always" (6). There are seventeen expressions or items on the scale. Expressions that measure the dimension of "emotional dissatisfaction" are 1, 2, 3, 4, 5, 7, 8. The expressions that measure the dimension of "behavioural alienation" are 10, 11, 12, 13, 14, 17 and the expressions that measure the dimension of "individual perception of success"

are 6, 9, 15, 16. Emotional dissatisfaction, behavioural alienation and individual perception of success are scored as “Never (1)” and “Always (6)” and are determined by collecting them separately for each subdimensions. The scores of the emotional dissatisfaction, behavioural alienation and individual perception of success subdimensions reflect that the burnout is high.

3.2.3. Work Conditions

In the third section, forty-three questions were asked about the conditions of the assistant physicians, such as their sociodemographic features, working conditions, nights and weekend shifts, occupational choice factors, and intentions to change their profession. Nine statements of working conditions were asked to assistant physicians. Their opinions about the work environment were evaluated with six options, 6-point Likert type scale “Never (1) and Always (6)”.

3.2.4. WHO (Five) Well-Being Index

In the fourth section, “WHO (Five) Well-Being Index” was used to measure their well-being. WHO-5 Questionnaire consists of five statements about the well-being of the participant in the last two weeks (WHO, 1998). The five items are as follows: “I felt joyful and pleasant.”, “I felt calm and relaxed”, “I felt active and vigorous.”, “I woke up in the morning feeling fresh and rested”, “My daily life is full of things that interest me”. Each item is evaluated between zero to five with a 6-point Likert type scale. 0 points indicate that there is no positive emotion in the past two weeks, 5-points indicate that there are continuous positive emotions. Raw scores are converted to a score between zero to ten. Below 50 points show a low emotional state and require additional examination. The questionnaire was translated into different languages including Turkish (WHO, 1998). Its reliability was previously performed by .85 (Mortvazi, Mousavi, Chaman, & Khosravi, 2015).

3.3. Procedure

Surveys were carried out online between February and March 2020 via SurveyMonkey program. Each participant sent the main survey link to their other

colleagues. Also, the QR code was produced for the participants who could not be able to access the link. This was sent to participants via e-mail. Before starting to answer the questionnaire, informed consent form was shown to participant. If they are voluntary at the research participation, they read and signed the form.

3.4. Data Analysis

The survey consists of eighty-eight questions in total. The data collected by the questionnaires were transferred to the SPSS 23.0 (Statistical Package for Social Sciences, version 23) program, and then statistical analyzes of the data were made using this program.

CHAPTER 4

RESULTS

4.1. Factor Analysis for the Scales

4.1.1. Mobbing Scale

Kaiser-Mayer-Olkin (KMO) test and Bartlett's Test of Sphericity were utilized to decide the construct validity of the mobbing scale. The KMO test result of Mobbing Scale is .957 and this value reflects the marvellous level. Bartlett test is also significant (X^2= 2502.405, *df*= 231, *p*= .000). The factor analysis was rehashed for three times to clarify the factorial structure. Items were excluded particularly since they took portion in more than one factor or their factor loadings were under .40 based on their importance in the factor. In this case, one item which was below .40 has been removed, and it was shown that explaining the 63.132% of the total variance. It was not appropriated with the scale harmony.

As seen in result, only one factor was defined, explaining 65.547% of the total variance. The one subdimension was named as "intimidation behaviours exerted by the chief". Then, six items were reversed in the SPSS program. After that, the reliability analysis of the scale was done within using the Cronbach Alpha coefficient method. As a result of the analysis, it was observed that the factor loadings of all items ranged between 0.617 and 0.942. Eigen values are 14.736. Cronbach Alpha value of Mobbing Scale is .976. It can be said that the survey is indicating perfect reliability. Table 4.1. shows the results of the Mobbing scale used in the research.

Table 4.1. Factor Analysis of the Mobbing Scale

Factors	*Factor Loadings*
15-(She/he) criticizes me unfairly.	0.942
22-(She/he) limits my educational opportunities.	0.927
13-(She/he) says the words that disruptive my self-confidence.	0.901
20-(She/he) makes claims against me while talking to others.	0.897
5-(She/he) interrupts my words.	0.871
19-(She/he) acts threatening to let me quit my job eventually.	0.870
11-(She/he) punishes me with his/her intimidating behaviour.	0.869
14-(She/he) assigns me with simple tasks far below my abilities because I am an assistant.	0.848
12-(She/he) gives feedback with a civilized language on the tasks that I carry out.	-0.844
23-(She/he) doesn't give enough information and leaves me learning something from others.	0.840
18-(She/he) is threatening me that leaving my speciality.	0.839
21-(She/he) makes me gossip material.	0.826
9-(She/he) put things on that seems silly to me, instead of the things I can improve myself.	0.801
3-(She/he) imposes communication constraints.	0.784
6-(She/he) makes me feel confident.	-0.784
8-(She/he) takes the job away from me and gives another job while focusing on a job.	0.767
10-(She/he) shows a motivating attitude for the work I do.	-0.764
17-(She/he) asks me for support regarding their private affairs	0.693
2-(She/he) conducts our relationship in a strict hierarchy.	0.686
1-(She/he) willings to give education.	-0.679
4-(She/he) allows me to take advantage of the personal development opportunities required by my specialization.	-0.653
16-(She/he) distributes the work fairly among the assistants.	-0.617

4.1.2. Burnout Inventory

Factor analysis was applied to determine the construct validity of the Burnout Inventory. In the beginning, the scale was created three factors. However, the results of the factors analysis showed that there is a two factor. At the first step, two items were removed from the scale, and 52.816% of the total variance was

explained. Then, it has been seen that two items were not appropriate for the scales. Therefore, they were removed from the scales. It was seen that two factors were defined explaining 57.915% of the total variance. Then, one item was removed from the scale. It was observed that 60.290% of the total variance was explained after the last step. In this scale, the five items which were below .40 has been removed and it was shown that explaining the 60.290% of the total variance. They were not appropriated with the scale. There is only one item left from the "Individual perception of success" factor, and this item is collected under the "emotional dissatisfaction" factor. "Individual perception of success" factor, which was thought before, has completely disappeared.

In epitome, the suitability of the data obtained for factor analysis was examined by Kaiser-Mayer-Olkin (KMO) test and Bartlett's Test of Sphericity. The KMO test result of Burnout Scale is .830. Bartlett test is significant (X^2= 783.411, df = 66, p = .000). Therefore, these results show that factor analysis is appropriate. The factor analysis was repeated for ten times to clarify the factorial structure. Items were excluded particularly since they took portion in more than two factors or their factor loadings were under .40 based on their importance in the factor.

In the result of the Burnout Inventory factor analysis, two factors were defined explaining the 60.290 % of the total variance. Past names of the scales and the substance of the items were considered whereas naming the components. Items that 1, 2, 3, 4, 5, 8, 9 refer to "emotional dissatisfaction" and 10, 11, 12, 13 and 14 refer to "behavioural alienation" were brought together as in two factors in the Burnout Inventory. Then, the reliability analysis of the scale was done within using the Cronbach Alpha coefficient method. Cronbach Alpha value of Burnout Inventory is .879. It can be said that the survey is indicating perfect reliability. However, Cronbach Alpha coefficients for the two sub-dimensions of the scale were .898 for emotional dissatisfaction, .891 for behavioural alienation. Eigen value of the emotional dissatisfaction is 5.437. The emotional dissatisfaction was defined explaining the 42.198% of the total variance. Also, Eigen value of the behavioural alienation is 2.525. The behavioural alienation was defined explaining the 18.092

% of the total variance. Table 4.2. shows the results of the Burnout Inventory used in the research.

Table 4.2. Factor Analysis of the Burnout Inventory

Factors	***Factor Loadings***
Factor 1= Emotional dissatisfaction (7 items)	
2- I feel personally worn out because of my high responsibility at work.	0.932
1-The extreme workload affects me negatively in an emotional way.	0.868
4-Trying to do many things at the same time exhausts me both physically and emotionally.	0.835
3- Taking the burden of responsibility alone wears me down.	0.766
5- I need to act fast due to lack of time.	0.742
9- I am so tired and exhausted after the night and weekend shifts that I cannot find time to devote to my social life.	0.59
8- I feel like I won't be on night and weekend shifts one more day.	0.525
Factor 2= Behavioural Alienation (5 items)	
11- I feel that I treat some of my patients like an object.	0.867
13- Since I started this profession, I think that I have become more insensitive to people.	0.859
14- I realized that I was also insensitive to the special people in my daily life.	0.742
12- Because of being focused on problem-solving at the hospital, I am generally careless in my daily life.	0.728
10- I feel tired of working with patients.	0.723

4.1.3. WHO (Five) Well-Being Index (WHO-5)

Factor analysis was applied to determine the construct validity of the WHO-5 Well-Being Index. It was determined that there was a problem in the 5th question. Therefore, this question was removed from the scale. The factor analysis was repeated for two times to clarify the factorial structure. When the factor analysis was done in two times, it is seen that items were included especially since they took part in one factor. As expected, only one factor occurred. Factor analysis was applied to determine the construct validity of this scale. First, the suitability of the data obtained for factor analysis was examined by Kaiser-Mayer-Olkin (KMO) test and Bartlett's Test of Sphericity. According to the test results, the KMO value is .795. Bartlett's Sphericity test result is also significant (X^2= 227.720, df= 6, p= .000). Therefore, these results show that factor analysis is appropriate. One factor, 66.714% of the total variance, was explained. On the other hand, Cronbach Alpha coefficient was examined for one factor. As a result of the analysis, it was observed that the factor loadings of all items ranged between 0.764 and 0.895. Eigen values are 2.994. The Cronbach Alpha of WHO (Five) Well-Being Index (WHO-5) is .889, and these values show that the survey is indicating perfect reliability. Table 4.3. shows the results of the WHO (Five) Well-Being Index used in the research.

Table 4.3. Factor Analysis of the WHO (Five) Well-Being Index

Factors	***Factor Loadings***
Factor 1= Well-being (4 items)	
3- I have felt active and vigorous.	0.895
2- I have felt calm and relaxed.	0.819
1- I have felt cheerful and in good spirits.	0.783
4- I woke up feeling fresh and rested.	0.764

4.1.4. Working Conditions

The form used to determine the working conditions consists of nine questions. With a 6-point Likert-type scale, the participant chooses one to six (Never (1) and Always (6)) points. Kaiser-Mayer-Olkin (KMO) test and Bartlett's

Test of Sphericity were used to determine the construct validity of the scale of the working conditions. According to the test results, the KMO value is .906, and this value reflects the marvellous level. Also, Barlett test is significant. (X^2= 771.711, *df* = 36, *p*= .000). Therefore, these results show that factor analysis is adequate. The factor analysis was repeated for one time to clarify the factorial structure. When the factor analysis was done in one time, it is seen that items were included especially since they took part in one factor. As expected, only one factor occurred. As a result, one factor was defined explaining 65.098% of the total variance. Eigen values are 6.185. Then, Cronbach Alpha test was applied to test the reliability of them. Cronbach Alpha value of "Working Conditions" is .941. Table 4.4. shows the results of the WHO (Five) Well-Being Index used in the research.

Table 4.4. Factor Analysis of the Working Conditions Scale

	Factor Loadings
4-In the environment where I work, convenience is provided for easy and comfortable work.	0.899
2- In the environment in which I work, physical (heat, light, building design ...) conditions are provided.	0.874
5-In the environment where I work, compliance with health conditions is provided.	0.862
3- In the environment where I work, technical (computer, printer, office equipment) conditions are provided.	0.847
7-The workplace where I work provides the appropriate equipment to improve my vocational education and service.	0.829
1- In the workplace where I work, necessary tools, equipment and materials are provided to do my job.	0.802
6- In the workplace where I work, the adequacy of cleaning services is provided (Hospital toilets, dining hall, etc.).	0.796
8- The workplace where I work provides the opportunity to reach the relevant authorities.	0.682
9- The number of assistant health personnel such as nurses, technicians and technicians is sufficient in the workplace where I work.	0.631

"The environment in which I work is compatible with the health conditions is provided." was the option that the majority was marked. 32.4% (27.5% + 4.9%) said five and always, 20.6% (3.9% + 16.7%) said two and never. The least preferred item in this group is, "The number of assistant health personnel such as nurses and technicians are sufficient in the workplace where I work'. While 8.8% (5.9% + 2.9%) people stated that they agree with this statement, 50.9% (17.6% + 33.3%) stated that they did not agree.

Table 4.5. Frequency of Working Conditions Items

	Mean	***Standard Deviation***
In the workplace where I work, necessary tools, equipment and materials are provided to do my job.	3.696	1.159
In the environment in which I work, physical (heat, light, building design ...) conditions are provided.	3.618	1.320
In the environment in which I work, technical (computer, printer, office equipment) conditions are provided.	3.647	1.272
In the environment where I work, convenience is provided for easy and comfortable work.	3.520	1.340
The environment in which I work is compatible with health conditions.	3.716	1.277
Adequacy of cleaning services is provided in the workplace where I work (Hospital toilets, dining hall, etc.).	3.608	1.351
The workplace where I work provides the appropriate equipment to improve my vocational education and service.	3.485	1.262
Whenever I have a problem at the workplace I work, I have access to the relevant authorities.	2.922	1.494
The number of assistant health personnel such as nurses, technicians is sufficient in the workplace where I work.	2.716	1.293

Eight multiple-choice questions were asked about the participants' choice of profession. As they can mark these options more than once, Table 4.6. shows

that reasons for selecting a career in medicine. The number of 102 exceeds the sample volume (N=102). Twenty-nine people (8.4%) marked with “My family’s socioeconomic level”, forty-nine people (14.2%) marked with “My family’s expectation and thoughts about me”, seventy-five people (21.8%) marked with “My wish and the thought that I can do this profession”, seventy-two people (20.9%) marked with “The idea of being in a respected profession group in the long term”, fifty people (14.5%) marked with “Job opportunities’, thirty-seven people marked with (10.8%) “Knowing the financial opportunities that my profession will bring”, ten people (2.9%) marked with “The influence of my friends, peers and my environment”, twenty-two people (6.4%) marked with because of the grades they received during the student period”. It was observed that “My own will is the thought that I can do this profession” is the most marked item.

Table 4.6. Frequency of the Reasons to Select a Career in Medicine

N=102	# of times selected*	Percentage of times selected
My own will is the thought that I can do this profession	75	73.5%
The thought of being in a respected professional group in the long run	72	70.6%
Job opportunities	50	49.0%
My family's expectation and thoughts about me	49	48.0%
Knowing the financial opportunities that my profession will bring	37	36.3%
My family's socioeconomic status	29	28.4%
The grades I got during the student period	22	216%
The impact of my friends, peers and my environment	10	9.8%

* Participants could choose multiple reasons in this question.

The intention of changing the profession was asked, and forty-eight people (47.1%) answered as “No”, and fifty-four people (52.9%) answered as “Yes”. Fifty-four people were asked how often they thought of changing the profession. The expressions were evaluated with one to six points as “Never” (1) and “Always” (6).

Table 4.7. shows that the most significant share is 4, which is a middle expression (n=17, 16.7%)

Table 4.7. Frequency of Intention of Changing the Profession

N=54	*Frequency*	*%*
Never=1	0	0.0
2	3	2.9
3	13	12.7
4	17	16.7
5	12	11.8
Always=6	9	8.8
Total	54	52.9

Seven multiple-choice questions were asked about the reasons for changing the profession. Fifty-four people answered the questions. The participant can mark these options more than once. The reasons for changing the profession are specified in Table 4.8. The number N=54 exceeds the sample volume. The responses follow as; seven answers (13.0%) were marked with "personality traits are not suitable for this profession', two answers (3.7%) were marked with "skills are not suitable for this profession', three answers (5.6%) were marked with "physical characteristics, gender are not suitable for this profession', forty-seven answers (87.0%) were marked with "being exposed to heavy working conditions', forty-three responses (76.91%) were marked with "high workload', twenty-five answers (46.3%) were marked with "restricted time allocated to family, friends and social environment', twenty-one answers (38.9%) were labelled with "time restriction on academic studies (thesis, research etc.)'. Considering the answers that were given, "Exposure to heavy working conditions" have the most volume among the factors that can change their profession. As can be seen from the results, the fact that assistant physicians exposure to heavy working conditions is a valid reason for their intention to change their jobs.

Table 4.8. Frequency of Reasons for Changing the Profession

N=54	# of times selected*	Percentage of times selected
My personality traits are not suitable for this profession	7	13.0%
My skills are not suitable for this profession	2	3.7%
Physical characteristics, gender not suitable for this profession	3	5.6%
Exposure to heavy working conditions	47	87.0%
High workload	43	76.9%
Restricting time for family, friends and social environment	25	46.3%
Restriction of time allocated for academic studies (thesis, research etc.)	21	38.9%

* Participants could choose multiple reasons in this question.

4.2. Analysis of Relationship Between Mobbing and Sociodemographic Features

When looking at exposure to mobbing, there is no difference in gender discrimination of the participants. There is no relationship between gender and exposure to mobbing behaviours (r= -0,104, p= .302). Also, as a result of Independent Samples T-test, no statistically significant difference was found between the two groups in terms of gender (M_{male}= 3.65, SD= 1.28; M_{female}= 3.38, SD= 1.35). Although many studies suggest that those exposed to mobbing differ by gender, this study found that there was no difference between mobbing and gender. Exposure to mobbing behaviour does not differ according to gender (t(99)= 1,038, p= 0.302).

A significant positive relationship was found between mobbing and age characteristics of the participants. (r= 0.222, p= .026). However, One-Way Anova Test, which is one of the parametric tests, was used to investigate whether the exposure to mobbing varies according to age. The perceptions of assistant physicians about exposure to mobbing differ according to the age variable (F= 2.692, p= .036). The homogeneity of the variances is ensured (p= 0.445 > 0.05).

For this reason, Tukey, which is one of the Post Hoc tests, was used to investigate the cause of the difference. Although the difference is not very large, it arises from the 26-28 and 29-31 age groups. The 29-31 age group is exposed to more mobbing than the 26-28 age group ($M_{26\text{-}28}$= 3.13; $M_{29\text{-}31}$= 3.85).

A positive, meaningful relationship was found between mobbing and the city where the participants worked. (r= 0.215, p= .031). One-Way ANOVA test was applied to understand whether the perception of mobbing differs according to the cities variable in which the participants work, and there was no difference between the groups.

A significant positive relationship was found between mobbing and the medical field in which the participants worked (r= 0.354, p< .001). One-Way Anova test was applied to understand whether the perception of mobbing differs according to the medical field. The difference arises from the participants who are working in Surgical Medical Sciences. The participants who are working in the Surgical Medical Sciences (M= 4.03) is exposed to more mobbing than the participant who is working in Internal Medical Sciences (M= 3.09). Also, a significant positive relationship was found between Mobbing and participants' specialities (r= 0.297, p= .003).

Considering the state of mobbing exposure with other demographic features, the results are given below. There is no relationship between marital status and exposure to mobbing behaviour (r= -0.079, p= .431). There is no relationship between the number of children and exposure to mobbing behaviours (r= -0.154, p= .125). There is no relationship between the type of hospital where they work and the exposure to mobbing (r= -0.077, p= .443). Also, there is no relationship between graduation years and mobbing (r= -0.004, p= .968). There is no relationship between the year of specialization and mobbing (r= -0.174, p= .083).

4.3. Analysis Between Burnout and Sociodemographic Features

Regarding the overall burnout levels, regardless of the sub-dimension, there is no difference in gender discrimination of the participants. There is no relationship between gender and burnout (r= -0.156, p= .121). Besides, as a result of

Independent Samples T-test, there was no statistically significant difference between the two groups in terms of gender (M_{male}= 4.56, *SD*= 0.93; M_{female}= 4.27, *SD*= 0.94). Although many studies suggest that burnout levels differ by gender, this study found that there was no difference between general burnout and gender. Regardless of gender, burnout does not differ according to female and male ($t(98)$= 1.565, p= .981). Whether there is a relationship between Emotional Dissatisfaction, which is one of the sub-dimensions of burnout, and gender was examined. There is no relationship between emotional dissatisfaction and gender (r= -0.080, p= .426). Whether there is a relationship between Behavioural Alienation, which is one of the sub-dimensions of burnout, and gender was examined. There is relationship between Behavioural Dissatisfaction dimension and gender (r= -0.144, p= .151).

Regarding the overall burnout levels, regardless of the sub-dimension, there was no positive relationship between burnout and age characteristics of the participants. (r= 0.186, p= .065). However; when the relationship between the sub-dimensions of burnout and age was tested; While there is a positive relationship between Emotional Dissatisfaction and age (r= -0.252, p= .011), there is no relationship found between Behavioural Alienation and age (r= -0.060, p= .554).

However, One-Way Anova test, one of the parametric tests, was used to investigate whether there was a difference between emotional dissatisfaction by age variable. The level of emotional dissatisfaction of assistant physicians varies according to the age variable (F= 5.326, p= .001). For this reason, the Tukey test, which one of the Post Hoc tests, was used to investigate the cause of the difference. The difference is due to the 22-25 and 32-35 age groups. The 32-35 age group experiences more burnout than the 22-25 age group ($M_{22\text{-}25}$ = 3.23; $M_{32\text{-}35}$ = 5.26).

Regardless of the sub-dimension of burnout, there was no significant relationship between burnout in general and the city in which the participants worked (r= 0.134, p= .185). Also, when the relationship between the sub-dimensions of burnout and the city they work in was tested; While there is no relationship between Emotional Dissatisfaction and city (r= -0.180, p= .071), and also there is no relationship found between Behavioural Alienation and city (r= -0.044, p = .662).

Regardless of the sub-dimension of burnout, a positive relationship was found between burnout in general and the field of medicine in which the participants worked. (r= 0.333, p= .001). Also, when the relationship between the sub-dimensions of burnout and medical field was tested; there is a significant positive relationship between Emotional Dissatisfaction (r= 0.307, p= .002) and medical field, and also there is a significant positive relationship found between Behavioural Alienation and medical field (r= 0.253, p= .011). "H3: There is a significant relationship between the burnout levels of the assistant physicians and the medical fields" was accepted, and the null hypothesis "H0: There is no relationship between burnout levels of the assistant physicians and the medical fields" was rejected.

Firstly, One-Way Anova test, one of the parametric tests, was applied to investigate whether the participants differed between emotional dissatisfaction according to the variable of the field of medicine which they worked. The perceptions of assistant physicians about emotional dissatisfaction differ according to the medical field variable (F= 10.273, p= .002). Assistant physicians working in Surgical Medical Sciences (M= 5.10) experience more emotional dissatisfaction than assistant physicians working in Internal Medical Sciences (M= 4.46). Secondly, One-Way Anova test, one of the parametric tests, was used to investigate whether the participants differed between behavioural alienation according to the medical field variable in which they worked. The perceptions of assistant physicians about behavioural alienation differ according to the variable of medicine field (F= 10.273, p= .011). Assistant physicians working in Surgical Medical Sciences (M= 4.26) experience more behavioural alienation than assistant physicians working in Internal Medical Sciences (M= 3.58)

Regardless of the sub-dimension of burnout, there is no significant relationship between burnout and the areas of expertise of the participants (r= 0.011, p= .913). However, when the relationship between the sub-dimensions of burnout and their expertise was tested; While there was no relationship between Emotional Dissatisfaction and their expertise (r= 0.101, p= .317), there is no relationship between Behavioural Alienation and their expertise (r= -0.068, p= .500).

Regardless of the sub-dimension of burnout, there is no relationship between burnout and marital status (r= -0.121, p= .231). Also, when the relationship between the sub-dimensions of burnout and marital status was tested; while there is no relationship between Emotional Satisfaction and marital status (r= -0.050, p= .621), and also there is no relationship between Behavioural Alienation and marital status (r= -0.126, p= .208).

Regardless of the sub-dimension burnout, there is no relationship between burnout and the number of children (r= -0.002, p= .984). Also, when the relationship between the sub-dimensions of burnout and the number of children was tested; while there is no relationship between Emotional Dissatisfaction and number of children (r= -0.050, p= .619), and also there is no relationship between Behavioural Alienation and number of children (r= 0.063, p= .534).

Regardless of the sub-dimension burnout, there is no relationship between the type of hospital where the participants work and the burnout (r= 0.071, p= .483). Besides, when the relationship between the sub-dimensions of burnout and the type of hospital was tested; while there was no relationship between Emotional Satisfaction and type of hospital (r= -0.040, p= .694), and also there is no relationship found between Behavioural Alienation and hospital type (r= 0.162, p= .105).

Regardless of the sub-dimension burnout, there is also no relationship between graduation years and burnout (r= -0.160, p= .113). Also, when the relationship between the sub-dimensions of burnout and the years of graduation was tested; while there is no relationship with Emotional Dissatisfaction and graduation years (r= -0.150, p= .134), and also there is no relationship between Behavioural Alienation and the year of graduation (r= -0.125, p= .214).

Regardless of the sub-dimension burnout, there is also no relationship between the year of starting specialization and burnout (r= -0.092, p= .361). Besides, when the relationship between the sub-dimensions of burnout and the years of specialization was tested; while there was no relationship with Emotional Satisfaction and year of starting specialization (r= -0.083, p= .408), and also there

is no relationship found between Behavioural Alienation and the year of starting specialization (r= -0.074, p= .465).

4.4. Analysis Between Mobbing and WHO-5 Well-Being Index

When the relations between Mobbing and WHO-5 are examined; it is seen that there is a strong negative relationship between mobbing and the well-being of the participant in the last two weeks (r= -0.434, p< .001). Therefore, as the level of exposure to mobbing increases, the well-being of the participant in the last two weeks decreases. As a result, the hypothesis established as "H3: There is a significant relationship between assistant physicians who exposure to mobbing, and well-being in the last two weeks." was accepted.

4.5. Analysis Between Burnout and WHO-5 Well-Being Index

When the relationships between burnout and WHO-5 Well-Being are examined, it is seen that there is a strong negative relationship between burnout and the well-being of the participant in the last two weeks (r= -0.360, p< .001). Therefore, as the burnout level increases, the well-being of the participant decreases in the last two weeks. When the relationship between the sub-dimensions of burnout and the well-being of the participant was tested; there is a strong negative relationship was found between emotional dissatisfaction and the well-being of the participant (r= -0.348, p< .001). Also, there is a relationship found between behavioural alienation and the well-being of the participant (r= -0.203, p= .042). As a result, the hypothesis established as "H5: There is a significant relationship between the burnout levels of assistant physicians and the state of well-being in the last two weeks" was accepted.

4.6. Relationship Between Mobbing and Burnout

The average, standard deviation, minimum and maximum levels and ranges related to the levels of mobbing exposure and burnout (emotional dissatisfaction and behavioural alienation) of the assistant physicians reached within the scope of the study are shown in Table 4.9. The table shows that the average mobbing score is lower than the average scores of burnout levels. The average of mobbing scores

of assistant physicians can be accepted as medium level with 3.51. On the other hand, it can be said that the average scores of burnout are at a medium level because of their proximity to approximately 4. It is understood that the standard averages of mobbing and burnout levels vary between 1.04 and 1.36.

Table 4.9. Descriptive Statistics of Mobbing and Burnout Levels (Emotional Dissatisfaction, Behavioural Alienation) (n=101)

Mobbing /Burnout		***Mean***	***Std. Dev.***	***Range***	***Min***	***Max***
Mobbing		3.5144	1.32459	4.64	1.27	5.91
Burnout	Emotional Dissatisfaction	4.7539	1.04493	4.71	1.29	6.00
	Behavioural Alienation	3.8950	1.36164	5.00	1.00	6.00

The mean, standard deviation and comparison of the mobbing, burnout levels (emotional dissatisfaction, behavioural alienation) of the physicians by gender are shown in Table 4.10. The table shows that there is no significant difference between the perception of assistant physicians exposure to mobbing by gender ($t(99)= 1.038$, $p= .630$). Also, Emotional dissatisfaction ($t(99)= 0.799$, $p= .834$) did not significantly differ according to the gender of assistant physicians and behavioural alienation ($t(99)= 1.447$, $p= .313$) did not significantly differ according to the gender of assistant physicians. Considering the results, the hypothesis established as "H1: Mobbing and burnout levels (emotional dissatisfaction, behavioural alienation) of assistant physicians differ according to the gender of assistant physicians" was rejected.

Table 4.10. Comparison of Mobbing and Burnout Levels (Emotional Dissatisfaction, Behavioural Alienation) by Gender (n=101)

		Gender					
		Male (n=48)		Female (n=53)			
		Mean	*Std. Deviation*	*Mean*	*Std. Deviation*	*t*	*p*
Mobbing		3.65	1.28	3.38	1.35	1.038	.630
Burnout	Emotional Dissatisfaction	4.83	1.06	4.67	1.03	0.799	.834
	Behavioural Alienation	4.10	1.41	3.70	1.29	1.447	.313

Mobbing, burnout levels (emotional dissatisfaction, behavioural alienation) of assistant physicians and average score, standard deviation and comparison according to the medical field are shown in Table 4.11. The table shows that there is no significant difference between exposure to mobbing by the medical field (t(99)= -3.770; p= .488). Also, it does not significantly differ from behavioural alienation according to the medical field (t(99) = -2,600; p= .907), but it is understood that there is a significant difference emotional dissatisfaction (t(99)= -3.205; p= .002) according to the medical field. Therefore, it was observed in this study that the work of assistant physicians in the internal medicine or surgical medical sciences partially affected the burnout perceptions, excluding mobbing. As a result, "H2: The levels of mobbing and burnout (emotional dissatisfaction, behavioural alienation) of assistant physicians differ significantly according to the medical fields of physicians" was rejected in terms of mobbing and behavioural alienation. However, it has been accepted for emotional dissatisfaction.

Table 4.11. Comparison of Mobbing and Burnout Levels (Emotional Dissatisfaction, Behavioural Alienation) by Medical Field (n=101)

		Medical Field					
		Internal Medical Sciences (n=56)		Surgical Medical Sciences (n=45)			
		Mean	*Std. Deviation*	*Mean*	*Std. Deviation*	*t*	*p*
Mobbing		3.10	1.27	4.04	1.21	-3.770	.488
Burnout	Emotional Dissatisfaction	4.46	1.18	5.10	0.73	-3.205	.002
	Behavioural Alienation	3.58	1.35	4.27	1.29	-2.600	.907

When the results of the correlation analysis are analyzed in general, it is seen that there is a significant and positive relationship between mobbing and burnout and this relationship is also very strong (r= 0.514, p< .001). Accordingly, as exposure to mobbing increases, levels of burnout in individuals also increase.

When the relationships between mobbing and sub-dimensions of burnout are examined, it is observed that there is a strong positive relationship between mobbing and "emotional dissatisfaction" dimension (r= 0.624, p< .001). Also, there is a positive relationship between mobbing and "behavioural alienation" (r= 0.225, p< .05). It is at a medium level. On the other hand, Table 4.12. shows that there is a positive relationship between mobbing and "emotional dissatisfaction"and "behavioural alienation'. Therefore, as the level of exposure to mobbing increases, the level of emotional dissatisfaction and behavioural alienation increases. The current study found positive relationships between mobbing, emotional dissatisfaction and behavioural alienation. Therefore, there are mutual increases between mobbing, emotional satisfaction and behavioural alienation. As a result, the hypothesis established as "H6: There is a significant relationship between the exposure of assistant physicians to mobbing, and their burnout perception (emotional dissatisfaction, behavioural alienation) was accepted. It is found that significant relationships were found between mobbing (intimidation behaviour by the chief) and burnout (emotional dissatisfaction, behavioural alienation).

Table 4.12. Correlations between Mobbing and Subdimensions of Burnout

		Mobbing	Emotional Dissatisfaction	Behavioural Alienation
Correlation	Mobbing	1		
	Emotional Dissatisfaction	.624**	1	
	Behavioural Alienation	.225*	.343**	1

** p< .001
*p< .05

Table 4.13. summarizes the relationship between mobbing and burnout according to the regression model. In the model, burnout is used as the dependent variable and mobbing is used as an independent variable. It shows that the model's correlation coefficient is 0.514 (r= 0.514). Mobbing exposure levels appear to explain 26.5% of the total variance in physicians" burnout levels (R^2= 0.265). The established regression model is linear, and the model was found statistically significant (F= 34.883; p< .001). When the beta coefficients of the applied regression model are examined, it is understood that the level of exposure to mobbing affects burnout. It has been found that mobbing positively determines burnout. Also, when the standardized Beta coefficients are examined, it was found that mobbing affects burnout (*Standard Beta coefficient*= 0.514; p< .001). Therefore, in this study, mobbing has been seen as an essential determinant of burnout. As a result, the hypothesis established as "H7: Mobbing significantly determines/affects the burnout levels of assistant physicians" was accepted.

Table 4.13. Summary of Regression Model Showing the Effects of Mobbing on Burnout

Model		Unstandardized Coefficients		Standardized Coefficients						
		B	*Std. Error*	*Beta*	*t*	*Sig.*	*F*	*Sig.*	*R*	*R2*
1	(Constant)	3.114	.236		13.191	.000	34.883	.000	.514	.265
	Mobbing	.369	.063	.514	5.906	.000				

a. Dependent Variable: Burnout

When looking at the relationship between mobbing and emotional dissatisfaction, which is one of the dimensions of burnout, emotional dissatisfaction was used as the dependent variable and mobbing was used as an independent variable. The regression model is summarized in Table 4.14. It shows that the model's correlation coefficient is 0.624 (r= 0.624). The level of exposure to mobbing seems to explain 38.9% of the total variance in physicians' level of emotional dissatisfaction (R^2= 0.389). The established regression model is linear, and the model was found statistically significant (F= 62.392; p< .001). When the beta coefficients of the regression model applied are examined, it is understood that the level of exposure to mobbing affects the emotional dissatisfaction dimension. Mobbing has been found to determine emotional dissatisfaction positively. Also, when the standardized Beta coefficients are examined, it was found that mobbing affects emotional dissatisfaction (*Standard Beta coefficient*= 0.624; p< .001). Therefore, in this study, mobbing has been seen as an essential determinant of emotional dissatisfaction, which is the sub-dimension of burnout. As a result, the hypothesis established as "H8: Mobbing significantly determines/affects the emotional dissatisfaction of assistant physicians"was accepted.

Table 4.14. Summary of Regression Model Showing the Effects of Mobbing on Emotional Dissatisfaction

Model		Unstandardized Coefficients		Standardized Coefficients						
		B	*Std. Error*	*Beta*	*t*	*Sig.*	*F*	*Sig.*	*R*	*R2*
1	(Constant)	3.054	.232		13.165	.000	62.392	.000	.624	.389
	Mobbing	.487	.062	.624	7.899	.000				

a. Dependent Variable: Emotional Dissatisfaction

When looking at the relationship between mobbing and behavioural alienation, which is another subdimension of burnout, behavioural alienation was used as a dependent variable and mobbing was used as an independent variable. The regression model made is summarized in Table 4.15. It shows that the model's correlation coefficient is 0.225. The level of exposure to mobbing seems to explain 5.1% of the total variance at the behavioural alienation level of physicians (R^2=

0.051). The established regression model is linear, and the model was found statistically significant (F= 5.217; p= .025). When the beta coefficients of the applied regression model are examined, it is understood that the level of exposure to mobbing affects the behavioural alienation dimension. It was found that mobbing positively determined behavioural alienation. Besides, when standardized Beta coefficients are examined, it was found that mobbing affects behavioural alienation (*Standard Beta coefficient*= 0.225; p= .025). Therefore, in this study, mobbing was found as an important determinant of behavioural alienation which is another sub-dimension of burnout. Thus, the hypothesis established as "H9: Mobbing significantly determines/affects the behavioural alienation of assistant physicians" was accepted.

Table 4.15. Summary of Regression Model Showing the Effects of Mobbing on Behavioural Alienation

Model		Unstandardized Coefficients		Standardized Coefficients						
		B	*Std. Error*	*Beta*	*t*	*Sig.*	*F*	*Sig.*	*R*	R^2
1	(Constant)	3.068	.383		8.002	.000	5.217	.025	.225	.051
	Mobbing	.232	.102	.225	2.284	.025				

a. Dependent Variable: Behavioural Alienation

By using hierarchical multiple regression analysis, a statistical meaning was created that defines the effect of the interaction variable, which is redefined using Mobbing and Burnout, which are considered as independent variables, on the dependent variable WHO-5 Well-Being. When it is desired to look at the effect of the interaction between mobbing and burnout on the WHO-5 Well-Being Index, the well-being index variable is used as the dependent variable, and the interaction between mobbing and burnout is used as an independent variable in the model. The regression model made is summarized in Table 4.16. It shows that the model's correlation coefficient is 0.539 (r= 0.539). The interaction of mobbing and burnout seems to explain 29% of the total variance at the level of physicians' well-being (R^2= 0.290). The established regression model is linear, and the model was found

statistically significant (F= 12.281; p< .001). When the beta coefficients of the regression model applied are examined, it is understood that the interaction between mobbing and burnout affects the well-being dimension of assistant physicians. The interaction of mobbing and burnout has been found to determine the well-being positively. Also, when the standardized Beta coefficients are examined, it was found that the state of well-being was affected by this interaction (*Standard Beta coefficient*= 0.539; p< .001). Thus, the hypothesis established as "H10: The interaction between mobbing and burnout significantly affects the well-being of assistant physicians" was accepted.

Table 4.16. Summary of Regression Model Showing the Effects of Interaction of Mobbing and Burnout on WHO-5 Well-Being Index

Model		Unstandardized Coefficients		Standardized Coefficients						
		B	*Std. Error*	*Beta*	*t*	*Sig.*	*F*	*Sig.*	*R*	*R2*
1	(Constant)	1.470	.087		16.962	.000	12.821	.000	.539	.290
	Mobbing	-.372	.092	-.413	-4.036	.000				
	Burnout	-.096	.093	-.107	-1.036	.303				
	Interaction	.232	.075	.225	2.797	.006				

a. Dependent Variable: WHO

CHAPTER 5

DISCUSSION

Mobbing behaviours are observed in every sector in the workplace, but they are more intense in the health sector. The health sector is an important institution that serves both healthy and sick individuals continuously. The first condition of a producing and developing society is healthy individuals. When this is possible, the health sector provides advanced and high-quality services. At this stage, healthcare professionals have significant duties. Assistant physicians who have an essential role in the healthcare sector, regularly interact with patients, patient relatives, nurses, managers and much other staff working together. From time to time, they have problems with these people and suffer both individually and professionally. These adverse impacts in the workplace can turn into mobbing behaviour. It affects people's lives negatively and also experiencing burnout.

It is challenging to find a cause-effect relationship in the mobbing process. Many factors can play a role in this situation. As we have seen in the literature, the phenomenon of mobbing is a vicious circle. It is necessary to identify the underlying causes to understand the cycle. A factor that can cause this phenomenon may also be the result of mobbing. The reasons or factors for mobbing can be individual, organizational or social. Also, a factor that may cause mobbing in one organization may not perform the same function in another organization (Toker, 2008).

However, it is a broad interpretation that burnout appears to be the most critical outcome of mobbing. Also, mobbing phenomenon has devastating consequences on the organization as well as on the individual. Besides, not only mobbing, but burnout phenomenon also creates severe problems in both individual and organization. Although today's rapid changes, heavy living conditions and work conditions affect all people, it is stated that burnout has a wide range of serious consequences. This combination leads to results such as a decrease in work efficiency and service quality, increases in quits, loss of experienced personnel (Şenturan, Gülseven Karabacak, Ecevit Alpar, & Sabuncu, 2009). Therefore, if an employer knows how serious the damage the mobbing will cause to business and is

equipped with information about possible outcomes, the employer will undoubtedly do her/his best to combat and end this process. Damages arising from the perspective of the employer are primarily of an economic nature (Tınaz, 2006).

These studies in the health sector are few. Especially when we consider the conditions experienced by assistant physicians, the current research has often shown that such situations are encountered. Besides, it is useful to find the work to be done for them to get out of these situations with little harm.

5.1 Implication of The Research

The health sector includes institutions with high work stress and complex structures, namely all kinds of hospitals. In this complexity, it is vital to provide accurate services to people. According to the human rights declaration, all people have the right to equal health care. For this reason, the healthcare providers, especially physicians, have a great responsibility in hospitals, which have a complex structure providing effective and efficient services with zero errors. The assistant physicians, who perform the medical profession and will be one of the future health protectors have a severe workload. Health institutions are organizations that have intense relationships and teamwork. In these organizations, they can face burnout as a result of the high stress when they are exposing to mobbing. The fact that hospitals can protect people's health rights by assistant physicians who are experiencing mobbing and burnout can cause significant losses for both the organization and the patients who receive services as a result.

In our study, the relationships between the levels of mobbing and burnout (emotional dissatisfaction, behavioural alienation) of assistant physicians who play a significant role in patient care and especially in hospitals are revealed. Also, this kind of variables was evaluated according to some demographic characteristics of assistant physicians. The study was carried out on assistant physicians that are working at the public and private university hospital and training and research hospitals based on the Ministry of Health in Turkey's. The burnout levels of the assistant physicians were measured by the "Burnout Inventory', which was tried to be developed by the researcher. Also, the exposure to mobbing behaviours was

measured by the “Mobbing Scale’, which was attempting to be created by the researcher. In the literature, the burnout phenomenon is mostly mentioned with the sub-dimensions such as emotional exhaustion, desensitization and personal accomplishment. The burnout phenomenon was tried to be observed for this research with the subdimensions such as emotional dissatisfaction and behavioural alienation. Also, intimidation behaviours exerted by the chief was discussed as the issue of mobbing. As a result of our study, the average of mobbing levels of assistant physicians was found 3.51. When it is evaluated at the point that expresses the six highest level, this average score can be an indicator of moderate mobbing. On the other hand, the average of burnout levels of assistant physicians was found with 4.75 for emotional dissatisfaction and 3.89 for behavioural alienation. When evaluated at the point that six expresses the highest level, it can be said that assistant physicians have moderate burnout. In the research, a significant relationship was found between mobbing and emotional dissatisfaction and behavioural alienation. Also, as a result of the regression analysis, it was understood that the mobbing levels of assistant physicians determined emotional dissatisfaction and behavioural alienation significantly. These results reveal that the mobbing should be reduced to decrease the burnout levels of assistant physicians in the hospitals where the research is conducted. Mobbing causes many negative business results, especially stress and burnout in employees. Within this study, the relationship of assistant physicians who were exposed to mobbing effect on burnout was found to be positive and significant. As a result of the analyses, these two variables also affect the well-being of the participants during the last two weeks. It is important to emphasize that the current study has shown the reasons for adverse variables. In the literature, we say that the massive workload, long working hours, and working conditions can cause mobbing. Afterwards, mobbing affects burnout. We see in the current study, the participants always show us that high workload and exposure to heavy working conditions are a critical point for changing their careers.

The outcomes of our study show parallel results of previous researches and differ with some cases of the literature and all national and international studies.

Ergin (1992) states that gender is a vital burnout variable; he reports that the desensitization subscale is not different in two genders, but women have more emotional exhaustion and men experience a decrease in their sense of personal accomplishment. In our study, it was observed that burnout value did not differ between men and women, and this difference did not make a significant difference as a result of the test. Regarding the similarity of this study, in a survey conducted by Schweitzer (1994) on young physicians, no difference was observed between the genders. The general view on this issue is that women take more care and attention to the people because of their gender roles. These situations create increasing their emotional exhaustion (Schweitzer, 1994). Again on a similarity, Yaman and Urgan (2002) did not find a significant difference between gender and in terms of 3 burnout dimensions in their research on family assistant physicians' perception of burnout. In our study, it was observed that emotional dissatisfaction and behavioural alienation, which are the sub-dimensions of burnout, did not differ significantly between male and female participants. Grunau (2007) found in his study that the relationship between mobbing and burnout did not differ according to gender. In our research, it was found that mobbing levels did not change significantly according to gender, as in the case of burnout. While some studies have found that age and number of years of working are not an essential determinant of burnout (Kirwan & Armstrong 1995; Goldberg et al., 1996), some studies have found significant relationships between individual characteristics such as age and marital status with especially emotional exhaustion (Ramirez, Graham, Richards, Gregory & Cull, 1996). In our study, although there was no significant relationship between burnout and age in general. However, a meaningful relationship was found with emotional dissatisfaction. There is no significant relationship was found with behavioural alienation. In many studies, the number of years of working of the participants was asked, but in this study, the year of specialization start was asked to obtain the working year information. As a result of our study analysis, no relation was found between the in general burnout, sub-dimensions and the year of starting to specialization. The relationship between the phenomenon of mobbing, which is another variable, and the year of beginning specialization, has been tested, but no

correlation has been found between mobbing and the year of starting specialization. In other words, starting year to specialization training shows some sort of assistant physician's position. No distinction was found regardless of whether it was Junior or Senior. Marital status was tested for each variable and did not cause a significant relationship or difference on burnout, burnout sub-dimensions and mobbing.

Erol et al. (2007) examined the relationship between burnout levels of physicians, depression and job satisfaction in their study on 135 assistant physicians. As a result of their research, they found that the desensitization levels of assistant physicians differed significantly according to the internal and surgical branches (Erol, Sarıçiçek & Gülseren, 2007). Our study concluded that the medical fields in which assistant physicians work, change the burnout significantly. Also, it has been determined that there is a significant relationship between medical fields and exposure to mobbing. In particular, it is seen that assistant physicians working in surgical medical sciences have significant relationships in burnout levels, as well as assistants working in surgical medical sciences are more exposed to mobbing. The absence of any participant from the basic medical sciences can be useful in the number of assistant physicians working in the surgical medical sciences in this relationship.

Grunau (2007) found significant relationships between mobbing and burnout dimensions in his research. Grunau (2007) points to the conclusion that the level of mobbing explains about 25% of the total variance in burnout dimensions. In our study, significant relationships were found between mobbing and burnout dimensions. It was determined that the mobbing level explained approximately 26.5% of the total variance in the burnout level. When the sub-dimensions of burnout and mobbing are analyzed, it is seen that the mobbing level explains approximately 38.9% of the total variance in the emotional dissatisfaction sub-dimension and the mobbing level explains 5.1% of the total difference in the behavioural alienation sub-dimension. Moreover, by creating a mobbing and burnout interaction, the well-being of the residents in the last 2 weeks was examined. When looking at the relationship between these variables and their well-being, it was observed that the well-being of the physicians who had burnout due

to mobbing was not good in the last two weeks. The well-being of people who experienced these situations could not be expected as normal.

In our study, strong relationships between the assistant perception of burnout and mobbing were found. It was observed that burnout levels increased by exposure to mobbing. In this sense, it can be considered that would be essential to find these great relationships between the burnout and mobbing perceptions of physicians working in hospitals, especially at the point of reducing the burnout and mobbing perceptions of physicians. At this point, it points to the importance of organizational psychology issues such as burnout and mobbing, which can cause psychological and psychiatric problems on physicians.

5.2 Limitations and Suggestions for the Future Studies

Before the research of the thesis, we wanted to create new scales that implicate assistant physicians" conditions. Afterwards, we formed the open-ended questionnaire. After this formation, I contacted my assistant physician friends to learn about their situations. Later, the study was carried out on a group of physicians with a questionnaire design that expressed the feelings and thoughts of eleven people. The statements made with the ideas of eleven people do not generalize to the opinions of the assistant physicians in this entire professional group. Moreover, research results were made randomly. In particular, their conditions are not generalizable with other physicians who are working in other hospitals of Turkey's cities. Another limitation is that the assistants' mobbing and burnout levels were measured subjectively since the responses were based on their perceptions and their personal opinions. Also, it should be taken into consideration that there may be effects (Hawthorne Effect) arising from the participants' knowing that the research was conducted. The questionnaire was asked not to name the participants to minimize such impacts. It was stated that the results of the study would not be used in evaluations related to the job.

No pilot studies have been conducted for the surveys before. Our study contained lots of variables. To better demonstrate this situation, the effects of the variables could be determined by applying pre-test and post-test. In order to see

which ones are more effective and to analyze their conditions better, conducting this study will be necessary for future studies. This may be a pretest for future studies. However, as said, it would be more logical to use with pre-test and post-test.

The scales used to measure mobbing and burnout conducted in the literature are internationally accepted measurement tools that have been used in many studies before. Their validity and reliability have been explained. However, in our study, validity and reliability of the questionnaires were measured that have not been done in any previous research. They are only tried to be developed for this study. However, the fact that such a study is performed with these measurement tools may carry many risks because it is new. Although validity and reliability scores are useful, questionnaires that need to be prepared with future research, they can be used rather than other scales by conducting large-scale research to develop. Other measurement tools are created with a universal language that can suit every person. However, these measurement tools contained expressions that only they could understand. Therefore, although the scales used are assumed to be measurement tools suitable for research purposes, they are not measurement tools that can be used for different groups. However, the purpose of this study was to design questionnaires that were trying to improve, for a specific group that reflect their sincere opinions. For this, it will be possible in the future to apply these scales to each level for the occupational groups in each sector and to present them across the country. Expressly, statements containing the feelings and thoughts of assistant physicians can only be accepted for this group. Many assistant physicians do not have nights and weekend shifts either by considering the working year of the assistant physicians or by their medical field. However, there are expressions about the night and weekend shifts in the scales that are tried to be developed for the survey study. These statements are not correct for physicians who do not have the nights and weekend shifts. The answers given to these statements may be misleading. This is a different limitation that has been processed for the construction of the research. Besides, in our study, although the sample size was 107, it was completed with 102 people due to missing data. The fact that the persons included

in the research are not in the desired amount may have determined the relationship between the variables in the result of the study. In my opinion, this requires a more comprehensive analysis with higher numerical data.

Mobbing and burnout levels of assistant physicians can cause such serious problems. It requires extensive studies on the subject with the intense workload experienced outside these situations. Also, determining that there is a relationship between the mobbing and burnout levels of assistant physicians would be essential to attract attention to prevent such behaviours. The burnout and mobbing levels of all occupational groups in the whole working system, especially for all professional groups in the health sector, can be done in different versions. However, in researches, occupational groups belonging to each industry may have cases of mobbing and burnout at different levels.

In our research, the issue of mobbing is limited only by the intimidation behaviours exerted by the chief. As speciality training depends on the master-apprentice relationship. Vertical mobbing has chosen for more specific to narrow the mobbing concept. As can be seen in the literature, mobbing can be monitored not only by one or more people in the top position but also by their intimidating behaviour on top of a colleague or person in the bottom place. When we talked to specialist doctors, it was discussed verbally that people experienced many conditions during the medical training process. It is essential to train these specialists, hospitals and all employees serving this environment. Such studies show us again how important education is. Because in work done, it is carried out to eliminate all negative processes by considering the next studies. In this case, we believe that training programs should be organized to raise awareness of the participants' chefs. As a result of the researches, it has been observed that the mobbing and burnout phenomenons affect employees, managers and the institutions along with it, and methods of dealing with the subject have been trying to be developed. Notably, the distribution of duties according to the talents, characteristics and priorities of the employees in the organizations is one of the most critical factors against burnout and mobbing. Peace and happiness of employees should be ensured by managers or chiefs. Thus, job satisfaction will be

provided in the long term. Besides, another essential point is the importance of teamwork in organizations. Therefore, employees will see themselves as an essential part of that group and organization (Üngüren, Doğan, Özmen, & Tekin, 2010). Any measures that can be taken to improve organizational conditions affect preventing burnout and mobbing or reducing adverse mechanism within the organization. Methods of coping at the organizational level are both more permanent than those at the individual level. It reinforces the idea that burnout and mobbing are an essential problem for the organization and should be prevented.

As additional information, research was carried out in Turkey. Many terms have been translated from Turkish. The current titles of the participants pass as assistant physicians. Many of the foreign sources, especially the United States and Canada, are using this term as assistant physicians. There are also medical residency statements in the United States terminology. In UK sources, it is referred to as physician associate. As a common point because of the language and culture difference, the expression of the assistant physicians was used in the study.

Considering the shortcomings and added values of this study, it would be created to conduct large-scale researches on other subjects such as mobbing, burnout, role conflict, role ambiguity, job satisfaction, stress, job performance, etc., of especially assistant physicians, nurses or healthcare professionals working in health institutions which are affiliated to the Ministry of Health. It will provide significant benefits both in terms of contribution to the literature and the efficient and effective use of human resources in the health sector. For future physicians who are trying to perform a sacred profession in which we can entrust our health, researching the subjects they are victims and making new suggestions will create a new consciousness for this profession group as well as for the whole society. The fact that mobbing and burnout cases, which carry serious occupational health and safety level risk, are so important that makes it necessary to take precautions for all employees in hospitals. Awareness of this problem is essential for the measures and the arrangements to be taken in terms of both management and employees in the workplaces. Recognition and identification of this risk, which has just started to be named; also economical and human consequences at the individual, organizational

and social level should also be known (Çöl, 2008). Because the medical speciality education process is a field that requires a multidisciplinary approach (Yılmaz, Uçar & Ertin, 2019). When we are looking at interviews and survey results, it is a preferred profession for assistant physicians. They set off with the thought that they can do this profession, according to the effects of excessive workload, the number of keeping the watch and the number of patients. As a result of the research, it was noteworthy that the problems such as the restriction of the time allocated for them are the subjects that should be analyzed in detail. In this training process, it is essential to regulate the working hours, distribute the workloads equally, provide the necessary equipment for academic orientations and provide the support needed for the assistant physicians. All of these will be tried to be developed with new studies. This study is an encouraging study to examine the relationship between mobbing and burnout levels in both the health sector and other business areas. Thus, future studies will be removed from both health workers and other workplace workers.

CONCLUSION

The relationships between mobbing and subdimension of burnout were tried to look with data such as gender, age, marital status, number of children, city, type of hospital, medical field, areas of speciality, graduation year from medical school, starting year to specialization training, working hours per day, number of patients per day, time allocated per patient, night and weekend shifts, working conditions, factors of selecting a career in medicine and intentions to change their profession. They are the necessary facts that are thought to be essential for obtaining meaningful relationships for other studies. Also, the facts such as how the well-being of assistant physicians are affected by these variables with the analyses and contents made are draft for new research. It is believed that it will significantly contribute to improving their self-confidence, business efficiency, and reduction of injustices faced by employees. When all these factors are examined, the assistants' exposure to mobbing and their burnout levels may be due to the nature of the profession. In recent years, it is seen that assistant physicians have been ignored as the "trainees", they are now approached only as “service providers”with the effect

of performance practice. They are crushed under the excessive workload, and they cannot get the value of their labour. If their demands are not fulfilled, and their successes are ignored, they have come to the stage of leaving. In physicians, this process is done within the framework of the master-apprentice relationship. They learn medical education not from books, but practices. However, as a result of the perception of performance and the return of works only, the master-apprentice relationship between physicians turned into a meaningless hierarchy. In this relationship, tensions may sometimes occur between the chief and assistant physicians. While the mentioned tensions are almost absent in some places, they can take young physicians to the stage of resignation sometimes in other areas. This situation often brings with it the suspicion of whether they are subject to the nature of their profession or the mobbing factor. It is also possible to define this kind of pressure as mobbing. For this reason, “meaningful”studies are hoped by young physicians in the face of these phenomena. It has been understood that there is a requirement that should not be overlooked in meeting a dynamic denominator capable of producing rational solutions.

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APPENDICES

APPENDIX A

Informed Consent Form in Turkish

BİLGİLENDİRİLMİŞ VE GÖNÜLLÜ ONAM FORMU

Değerli katılımcı,

Bu çalışma İstanbul Bilgi Üniversitesi Sosyal Bilimler Enstitüsü Endüstriyel/Örgütsel Psikoloji Yüksek Lisans Programı yönetiminde, Doç. Dr. İdil IŞIK danışmanlığı tarafından yürütülmekte ve tez çalışması adına yapılacak olan "Asistan Hekimlerin Tükenmişlik ve Mobbing Düzeylerinin Araştırılması' adlı araştırmanın uygulama kısmına veri toplamak amacıyla hazırlanmıştır. Vereceğiniz tüm bilgiler gizli tutulacak, hiçbir kimse ve/veya kuruluşa verilmeyecektir. Soruları dikkatli okuyarak objektif, samimi, gerçek duygu ve düşüncelerinizi yansıtmanız araştırmanın amacına ulaşması için önemlidir.

Araştırmada yer alan soruların katılımcılar açısından olumsuz etkileri olması beklenmemektedir. Bu çalışmaya katılımınız tamamen isteğe bağlıdır. Çalışmadan elde edilen veriler gizli tutulacak ve bilimsel araştırma için kullanılacaktır.

Anketlere ayıracağınız zaman ve göstereceğiniz özenden dolayı şimdiden teşekkür ederim.

Begüm GENÇELLİ
0537 885 63 94
E-mail: begumgencelli@hotmail.com

APPENDIX B

Informed Consent Form in English

INFORMED CONSENT FORM

Dear participant,

This study is under the direction of the Industrial/Organizational Psychology Graduate Program of Istanbul Bilgi University, and it is conducted by Associate Professor İdil IŞIK consultancy. These questionnaires are prepared to collect data for the application part of the thesis, which is called "*Investigation of Burnout and Mobbing Levels of Assistant Physicians*'. All information you provide will be kept confidential and will not be given to anyone or organization. Reading the questions carefully, reflecting your objective feelings and thoughts are important for the research.

The questions in the study are not expected to have negative effects on the participants. Your participation in the research is entirely voluntary. The data obtained from the questionnaire will be kept confidential and used for scientific research.

Thank you in advance for your time and attention.

Begüm GENÇELLİ
Phone: 0537 885 63 94
E-mail: begumgencelli@hotmail.com

APPENDIX C

Turkish Version of Sociodemographic Data Form

SOSYODEMOGRAFİK ÖZELLİKLER FORMU

1. **Cinsiyetiniz:**

(1) Erkek

(2) Kadın

2. Yaşınız:

(1) 22-25

(2) 26-28

(3) 29-31

(4) 32-35

(5) >35

3. Medeni Durumunuz:

(1) Bekar

(2) Evli

(3) Boşanmış/Dul

4. Çocuk Sayınız:

(1) Yok

(2) 1

(2) 2

(3) 3

(4) >4

5. Hangi şehirde görev yapıyorsunuz? ……

6. Hangi kurumda çalışıyorsunuz?

(1) (Özel) Üniversite Hastanesi

(2) (Devlet) Üniversite Hastanesi

(3) Eğitim ve Araştırma Hastanesi

7. Fakülteden kaç yılında mezun oldunuz? ……

8. Uzmanlık eğitimine kaç yılında başladınız? ……

9. Hangi tıp alanında görev yapıyorsunuz?

(1) Temel Tıp Bilimleri

(2) Dahili Tıp Bilimleri

(3) Cerrahi Tıp Bilimleri

10. Seçmiş olduğunuz alanın hangi bölümünde uzmanlık eğitimi görüyorsunuz? ……..

11. Günde kaç saat çalışıyorsunuz? ……

12. Günde ortalama kaç hasta görüyorsunuz? ……

13. Hasta başına ortalama ne kadar süre ayırıyorsunuz? ……

14. Nöbet tutuyor musunuz?

(1) Hayır

(2) Evet

15. Ayda ortalama kaç nöbet tutuyorsunuz?

(1) 1-5

(2) 6-10

(3) 11 ve daha fazla

16. Nöbet sayınız mesleki eğitimin ve hizmetin gerektirdiği yasal sayının üstünde mi?

(1) Hayır

(2) Evet

17. Nöbet ertesinde izin kullanabiliyor musunuz?

(1) Hayır.

(2) Sabah devir sonrası izin kullanabiliyorum.

(3) Mesai öğlene kadar devam ediyor.

18. Aşağıda çalışma ortamı ve koşullarını içeren bazı ifadeler yer almaktadır. Kendi çalışma koşullarınızı göz önünde bulundurarak "Hiçbir zaman' (1) ile "Her Zaman' (6) arasında uygun olan sayısal değeri seçiniz.

"Hiçbir zaman (1) (2) (3) (4) (5) Her Zaman (6)'

(1) Çalıştığım işyerinde, işimi yapmak için gerekli araç, donanım ve materyal sağlanmaktadır.

(2) Çalıştığım ortamda, fiziksel (ısı, ışık, bina tasarımı...) şartların uygunluğu sağlanmaktadır.

(3) Çalıştığım ortamda, teknik (bilgisayar, yazıcı, büro malzemesi) şartların uygunluğu sağlanmaktadır.
(4) Çalıştığım ortamda, işin kolay, rahat yapılabilmesine uygunluk sağlanmaktadır.
(5) Çalıştığım ortamda, sağlık koşullarına uygunluğu sağlanmaktadır.
(6) Çalıştığım işyerinde temizlik hizmetlerinin yeterliliği sağlanmaktadır (Hastane tuvaletleri, yemekhane vb.).
(7) Çalıştığım işyeri, mesleki eğitimim ve hizmetimin geliştirilmesi için uygun donanımı sağlamaktadır.
(8) Çalıştığım işyerinde bir problemim olduğunda ilgili mercilere/yetkililere ulaşma imkânı sağlamaktadır.
(10) Çalıştığım iş yerinde hemşire, tekniker, teknisyen gibi yardımcı sağlık personel sayısı yeterlidir.

19. Aşağıda meslek seçimine ait bazı ifadeler yer almaktadır. Kendi meslek seçiminizi düşünerek, neden bu mesleği seçtiğinize dair görüşlerinizi ilgili maddelerde yer alan size en uygun ifadeleri işaretleyerek belirtiniz. (Birden çok seçenek işaretleyebilirsiniz.)

(1) Ailemin sosyoekonomik durumu
(2) Ailemin beklentisi ve benim hakkımdaki düşünceleri
(3) Kendi isteğim, bu mesleği yapabileceğim düşüncesi
(4) Uzun vadede saygın bir meslek grubu içerisinde olma düşüncesi
(5) İş bulma imkânı
(6) Mesleğimin kazandıracağı maddi imkanları bilmek
(7) Arkadaşlarımın, akranlarımın ve çevremin etkisi
(8) Öğrenci döneminde aldığım notlar
(9) Diğer. (Lütfen belirtiniz)

20. Fırsatınız olsa, mesleğinizi değiştirmeyi düşünür müsünüz?

(1) Hayır
(2) Evet

21. Mesleğinizi ne sıklıkla değiştirmeyi düşünürsünüz?

(1) Hiçbir zaman (2) (3) (4) (5) (6) Her zaman

22. Mesleği değiştirmeyi düşünmenize neden olabilecek faktörler aşağıdaki ifadelerden hangileri olabilirdi? (Birden çok seçenek işaretleyebilirsiniz.)

(1) Kişilik özelliklerimin bu mesleğe uygun olmaması

(2) Yeteneklerimin bu mesleğe uygun olmaması

(3) Fiziksel özelliklerin, cinsiyetin bu mesleğe uygun olmaması

(4) Ağır çalışma koşullarına maruz kalınması

(5) İş yükünün fazla olması

(6) Aile, arkadaş ve sosyal çevreye ayrılan zamanı kısıtlaması

(7) Akademik çalışmalara (tez, araştırma vs) ayrılan zamanı kısıtlaması

(8) Diğer (Lütfen belirtiniz)

APPENDIX D

English Version of Sociodemographic Data Form

SOCIODEMOGRAPHIC FEATURES FORM

1. Gender:

(1) Male

(2) Female

2. Age:

(1) 22-25

(2) 26-28

(3) 29-31

(4) 32-35

(5) >35

3. Marital Status:

(1) Single

(2) Married

(3) Divorced / Widowed

4. Number of Children:

(1) None

(2) 1

(2) 2

(3) 3

(4) >4

5. In which city do you work? ……

6. In which institution do you work?

(1) (Private) University Hospital

(2) (Public) University Hospital

(3) Training and Research Hospital

7. In how many years did you graduate from the faculty? ……

8. In how many years did you start specialization training? ……

9. In which medical field do you work?

(1) Basic Medical Sciences

(2) Internal Medical Sciences

(3) Surgical Medical Sciences

10. In which part of the field that you are studying specialization? ……

11. How many hours in a day do you work? ……

12. How many patients do you see on average per day? ……

13. How much time do you spend on average per patient? ……

14. Do you have the night and weekend shifts?

(1) No

(2) Yes

15. How many nights and weekend shifts do you keep on average per month?

(1) 1-5

(2) 6-10

(3) 11 and more

16. Is your night and weekend shifts count above the legal number required by vocational education and service?

(1) No

(2) Yes

17. Can you use the day off after the night and weekend shifts?

(1) No

(2) I can use leave after the morning transfer.

(3) The work continues until noon.

18. Some statements including the working environment and conditions are given below. Select the appropriate numerical value between 'Never' (1) and 'Always' (6), taking into account your working conditions.

"Never (1) (2) (3) (4) (5) Always (6)'

(1) In the workplace where I work, necessary tools, equipment and materials are provided to do my job.

(2) In the environment in which I work, physical (heat, light, building design ...) conditions are provided.

(3) In the environment where I work, technical (computer, printer, office equipment) conditions are provided.

(4) In the environment where I work, convenience is provided for easy and comfortable work.

(5) In the environment where I work, compliance with health conditions is provided.

(6) In the workplace where I work, the adequacy of cleaning services is provided (Hospital toilets, dining hall, etc.).

(7) The workplace where I work provides the appropriate equipment to improve my vocational education and service.

(8) The workplace where I work provides the opportunity to reach the relevant authorities.

(10) The number of assistant health personnel such as nurses, technicians and technicians is sufficient in the workplace where I work.

19. Some statements about the choice of profession are given below. Consider your own choice of profession and state your opinions about why you chose this profession by marking the most appropriate expressions in the relevant articles. (You can choose multiple options.)

(1) My family's socioeconomic status

(2) My family's expectation and thoughts about me

(3) My own will is the thought that I can do this profession

(4) The thought of being in a respected professional group in the long run

(5) Job opportunity

(6) Knowing the financial opportunities that my profession will bring

(7) The impact of my friends, peers and my environment

(8) The grades I got during the student period

(9) Other. (Please specify)

20. If you had the opportunity, would you consider changing your profession?

(1) No

(2) Yes

21. How often would you consider changing your profession?

(1) Never (2) (3) (4) (5) (6) Always

22. What could be the following factors that may have caused you to think about changing the profession? (You can choose multiple options.)

(1) My personality traits are not suitable for this profession

(2) My skills are not suitable for this profession

(3) Physical characteristics, gender not suitable for this profession

(4) Exposure to heavy working conditions

(5) High workload

(6) Restricting time for family, friends and social environment

(7) Restriction of time allocated for academic studies (thesis, research etc.)

(8) Other. (Please specify)

APPENDIX E

Turkish Version of Burnout Inventory

TÜKENMİŞLİK ENVANTERİ

Aşağıda bireylerin işleri ile ilgili tutumlarını yansıtan ifadeler yer almaktadır. Her maddede yer alan durumu ne sıklıkla yaşadığınızı düşünerek "Hiçbir Zaman' (1) ile "Her Zaman' (6) arasında uygun olan değeri seçiniz.

1. İş yükümün fazla olması beni duygusal olarak olumsuz etkiliyor.
2. İş yerinde sorumluluğumun fazla olmasından dolayı, kişisel olarak yıprandığımı hissediyorum.
3. Tek başıma sorumluluğu yüklenmek beni yıpratıyor.
4. Birçok işi aynı anda yapmaya çalışmak, beni hem fiziksel hem de duygusal olarak yoruyor.
5. Zaman yetersizliğinden dolayı hızlı hareket etme gereksinimi duyuyorum.
6. Ne kadar yoğun çalışsam da hastaların sorunlarına çözüm bulabilecek enerjiyi ve zamanı yaratabiliyorum.
7.Hem hasta ile hem de hasta yakınları ile uğraşmanın oldukça yorucu olduğunu düşünüyorum.
8. Bir gün daha nöbete kalamayacak gibi hissediyorum.
9. Nöbet sonrasında o kadar yorgun ve tükenmiş oluyorum ki sosyal hayatıma ayıracak zaman bulamıyorum.
10. Hastalar ile çalışmaktan bıktığımı hissediyorum.
11. Bazı hastalarıma sanki insan değil de bir objeymiş gibi davrandığımı hissediyorum.
12. Hastanede sürekli problem çözme odaklı davrandığım için iş dışında günlük hayatımda umursamaz oluyorum.
13. Bu mesleğe başladığımdan beri giderek insanlara karşı duyarsızlaştığımı düşünüyorum.
14. Özel hayatımdaki insanlara karşı giderek daha duyarsız davrandığımı fark ediyorum.
15. Yaşadığım duygusal problemleri sakin bir şekilde halletmeye çalışıyorum.
16. Doktorluk mesleğinin gerektirdiği niteliklere sahibim.
17. İşimle ilgili donanımımın yeterli olduğunu bilmeme rağmen, bir sorun ortaya çıktığında hastaların beni suçlama eğiliminden rahatsız oluyorum.

APPENDIX F

English Version of Burnout Inventory

BURNOUT INVENTORY

Statements that reflect the attitudes of individuals about their jobs are given below. Choose the appropriate value between “Never’ (1) and “Always’ (6), considering how often you experience the situation in each item.

1. The extreme workload affects me negatively in an emotional way.
2. I feel personally worn out because of my high responsibility at work.
3. Taking the burden of responsibility alone wears me down.
4. Trying to do many things at the same time exhausts me both physically and emotionally.
5. I need to act fast due to lack of time.
6. No matter how hard I work; I can create energy and time to find solutions to problems.
7. I think it is quite tiring to look at the patient and deal with the patient's relatives.
8. I feel like I won't be on night and weekend shifts one more day.
9. I am so tired and exhausted after the night and weekend shifts that I cannot find time to devote to my social life.
10. I feel tired of working with patients.
11. I feel that I treat some of my patients like an object.
12. Because of being focused on problem-solving at the hospital, I am generally careless in my daily life.
13. Since I started this profession, I think that I have become more insensitive to people.
14. I realized that I was also insensitive to the special people in my daily life.
15. I deal with emotional problems very calmly.
16. I have the qualifications required by the medical profession.
17. Although I know that my work equipment is sufficient, I am disturbed by the tendency of patients to blame me when a problem arises.

APPENDIX G

Turkish Version of Mobbing Inventory

MOBBİNG ÖLÇEĞİ

Lütfen aşağıdaki soruları bağlı olduğunuz üstünüzü/şefinizi düşünerek yanıtlayınız. Aşağıda sıralanan davranışlarla karşılaşma sıklığınızı her ifadenin yanındaki ölçek üzerinden değerlendiriniz. Üstünüz ya da şefinizin bu davranışları ne sıklıkla gösterdiğini düşünerek "Hiçbir Zaman' (1) ile "Her Zaman' (6) arasında uygun olan sayısal değeri seçiniz.

1. eğitim vermekte isteklidir.
2. ilişkimizi katı bir hiyerarşi içerisinde yürütür.
3. iletişim kısıtları getirir.
4. ihtisasımın gerektirdiği kişisel gelişim imkanlarından yararlanmama imkân tanır.
5. sözlerimi yarıda keser.
6. bana güvendiğini hissettirir.
7. üstlendiğim her işi ince ince izler.
8. bir işe odaklanmışken onu elimden alıp başka bir iş verir.
9. kendimi geliştirebileceğim işler yerine, bana saçma gelen işleri üzerime yıkar.
10. yaptığım iş/işler için motive edici bir tutum gösterir.
11. yıldırıcı davranışları ile beni cezalandırır.
12. yürüttüğüm görevlerle ilgili geribildirimi medeni bir dille verir.
13. özgüvenimi zedeleyici sözler söyler.
14. asistan olduğum için yeteneklerimin çok altında basit işlerle görevlendirir.
15. beni haksız yere olumsuz eleştirir.
16. işleri asistanlar arasında adil bir şekilde dağıtır.
17. özel işleriyle ilgili benden destek ister.
18. ihtisasımı yakma tehditlerinde bulunur.
19. sonunda işimi bırakıp gitmemi sağlamak için tehditkâr davranır.
20. başkalarıyla konuşurken aleyhimde iddialarda bulunur.
21. beni dedikodu malzemesi haline getirir.
22. eğitim imkanlarımı kısıtlar.
23. yeterince bilgi vermez ve beni bir şeyleri başkalarından öğrenmek durumunda bırakır.

APPENDIX H

English Version of Mobbing Inventory

Please answer the following questions by considering your supervisor/chief. Evaluate your frequency of encountering the behaviours listed below on the scale next to each statement. Choose the appropriate numerical value between "Never' (1) and "Always' (6), considering how often your supervisor or chef shows these behaviours.

1. (She/he) willings to give education.
2. (She/he) conducts our relationship in a strict hierarchy.
3. (She/he) imposes communication constraints.
4. (She/he) allows me to take advantage of the personal development opportunities required by my specialization.
5. (She/he) interrupts my words.
6. (She/he) makes me feel confident.
7. (She/he) constantly monitors every job I undertake.
8. (She/he) takes the job away from me and gives another job while focusing on a job.
9. (She/he) put things on that seems silly to me, instead of the things I can improve myself.
10. (She/he) shows a motivating attitude for the work I do.
11. (She/he) punishes me with his/her intimidating behaviour.
12. (She/he) gives feedback with a civilized language on the tasks that I carry out.
13. (She/he) says the words that disruptive my self-confidence.
14. (She/he) assigns me with simple tasks far below my abilities because I am an assistant.
15. (She/he) criticizes me unfairly.
16. (She/he) distributes the work fairly among the assistants.
17. (She/he) asks me for support regarding their private affairs
18. (She/he) is threatening me that leaving my speciality.
19. (She/he) acts threatening to let me quit my job eventually.
20. (She/he) makes claims against me while talking to others.
21. (She/he) makes me gossip material.
22. (She/he) limits my educational opportunities.

23. (She/he) doesn't give enough information and leaves me learning something from others.

APPENDIX I

Turkish Version of WHO-5 Five Factor Wellness Inventory

DSÖ-5 BEŞ FAKTÖRLÜ İYİLİK HALİ ENVANTERİ

Son iki hafta içindeki duygu durumunuzu düşünerek aşağıdaki her bir ifadeyi ne sıklıkla deneyimlediğinizi "Hiçbir Zaman' (0) ile "Her Zaman' (5) arasında size en uygun şekilde işaretleyiniz.

Son İki Hafta Boyunca	**Hiçbir Zaman**	**Bazen**	**Geçen Zamanın Yarısından Daha Azında**	**Geçen Zamanın Yarısından Çoğunda**	**Çoğu Zaman**	**Her Zaman**
	0	**1**	**2**	**3**	**4**	**5**

1. Kendimi neşeli ve keyifli hissettim.
2. Kendimi sakin ve gevşemiş hissettim.
3. Kendimi aktif ve dinç hissettim.
4. Sabahları kendimi taze ve dinlenmiş hissederek uyandım.
5. Günlük yaşantım beni ilgilendiren şeylerle dolu.

APPENDIX J

English Version of WHO-5 Five Factor Wellness Inventory

WHO-5 FIVE FACTOR WELLNESS INVENTORY

Consider your emotional state in the past two weeks and mark how often you experienced each of the expressions below, between "Never' (0) and "Always' (5).

Over the last two weeks	**At no time**	**Some of the time**	**Less than half of the time**	**More than half of the time**	**Most of the time**	**All of the time**
	0	**1**	**2**	**3**	**4**	**5**

1. I have felt cheerful and in good spirits.
2. I have felt calm and relaxed.
3. I have felt active and vigorous.
4. I woke up feeling fresh and rested.
5. My daily life has been filled with things that interest me.

APPENDIX K

The Ethics Committee Approval Form

ETİK KURUL DEĞERLENDİRME SONUCU / RESULT OF EVALUATION BY THE ETHICS COMMİTTEE

Covid-19 salgını nedeniyle İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurulu, 2019-2020 Bahar dönemimde teslim edilecek lisansüstü tezlerin onay yetkisini ilgili etik kurul alt komitelerine devretmiştir. / Due to the Covid-19 outbreak, Istanbul Bilgi University Human Research Ethics Committee has transferred its approval authority to the Ethics Board Sub-Committees organized within each graduate program. Thus, the graduate theses to be submitted in the spring semester of 2019-2020 should/must get the approval of the Ethics Board Sub-Committee within their own graduate program.

ETİK KURUL ALT KOMİTESİ DEĞERLENDİRME SONUCU / ETHICS BOARD SUB-COMMITTEE EVALUATION RESULT

Bu bölüm lisansüstü tez araştırmaları için ilgili Etik Kurul alt komitesince doldurulacaktır. / This part to be completed by the Ethics Board sub-committee responsible for graduate dissertation studies.

Başvuru Sahibi / Applicant: **Begüm Gençelli**

Proje Başlığı / Project Title: **Investigation of Burnout and Mobbing Levels of Assistant Physicians**

Değerlendirme Sonucu/ Result of Evaluation

1.Herhangi bir değişikliğe gerek yoktur. Veri toplama/uygulama başlatılabilir./ There is no need for revision. Data collection/application may commence : X

2. Ret / Application Rejected : _____

Reddin gerekçesi / Reason of Rejection : _____

Değerlendirme Tarihi / Date of Evaluation: **02.12.2019**

Unvanı, Adı, Soyadı / Title, Name, Surname:

İmza / Signature:

Dr. Öğr. Üyesi. Ümit Akırmak **Dr. Öğr. Üyesi. Gergely Czukor**