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Research Article

Relationship Between Professional Quality of Life and Work Alienation Among Healthcare Professionals

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Abstract

AIM: This study aimed to determine the levels of professional quality of life and work alienation of healthcare professionals.

METHODS: This study is descriptive and cross-sectional. A total of 1523 healthcare professionals from 13 cities across Turkey participated in the research. The data were collected in June 2019 using the Professional Quality of Life scale and the Work Alienation scale. Descriptive, correlational, and parametric comparative analyses were used to analyze data.

RESULTS: The mean professional quality of life score of healthcare professionals was 2.23 ± .61, and the subscale with the highest score was Compassion Satisfaction (M=3.44 ± 1.29). The mean score for work alienation in healthcare professionals was 2.84 ± .29, and the subscale with the highest score was Powerlessness (M=2.94 ± .50). A negative, very weak and significant relationship ($r = -.073$; $p < .05$) was determined between the scores obtained from the two scales. The total professional quality of life score of healthcare professionals significantly differed according to gender, profession, and unit. The total work alienation score of healthcare professionals significantly differed depending on the age groups, marital status, education level, position, professional experience, weekly working hours, working overtime, and working shift ($p < .01$; $p < .001$).

CONCLUSION: It was determined that the professional quality of life and work alienation levels of the healthcare professionals were slightly below the average and there was a very weak and negative relationship between them. Managers can improve the professional quality of life by implementing intervention programs in their work environment and decrease work alienation by assigning them to positions suitable to their values and beliefs.

Keywords: Behavior, health personnel, healthcare health services administration, nurses, nursing

Introduction

A safe and healthy working environment is considered a fundamental human right, and as in all sectors, it is one of the issues of importance in the health sector. The working environment and conditions directly affect the quality of employees' work life. Due to the nature of healthcare services (being both personal, changeable, complex, and often urgent), organizational changes in working conditions may cause employees to feel intense pressure and negatively affect their quality of work life (Yılmaz, 2018).

Quality of work life is defined as "a condition of psychological separation from one's image and social relations inside and outside the workplace" (Amarat et al., 2019). In fact, it defines the subjective satisfaction expressed by the employee in the physical, mental, social, and spiritual domains. Therefore, it is a concept that varies from person to person, and depends on the ability of each individual to deal with a situation. Professional quality of life (PQoL), on the other hand, is defined as "the quality perceived by a professional related to work as a service provider" (Stamm, 2010). There are three aspects of PQoL,

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namely compassion satisfaction (CS), as a positive aspect, and compassion fatigue (CF) and burnout (BO), as negative aspects (Stamm, 2010). High PQoL can increase the satisfaction of people with their work environment and affect the employees' interest in work, their relations with colleagues and managers, mitigate risks associated with workplace such as stress and fatigue, and other specific factors (Ioannou et al., 2015). All kinds of practices aimed at improving the health and well-being of employees have the potential to produce positive results in teamwork and interprofessional cooperation, by encouraging their participation. In this way, it is possible to increase autonomy and decrease stress and BO by enabling employees to make more independent decisions (Kaiser et al., 2018). Otherwise, a decrease in the PQoL may have negative effects on employees in various physical, social, and psychological aspects.

There is increasing competitiveness as the number of healthcare organizations increase day by day. The increase in the level of competition necessitates the obligation to perform better than competitors and to increase the quality of care. In order for healthcare organizations to be successful, they need to benefit from the human factor at the highest level. Providing employee satisfaction is underlined as a way of doing this, by improving the environment and conditions offered to the employees. On the other hand, due to the nature of the services provided in healthcare organizations, it is an almost universally accepted view that healthcare professionals are under high stress (Taycan et al., 2006). The satisfaction of healthcare professionals working under intense stress with excessive workload and struggling with many problems, may not be easily achieved. On the contrary, interpersonal conflicts in the work environment, inability to meet employees' expectations, the lack of autonomy, and frequent shifts in roles can have negative effects on both patient care and employee behavior. This may be the reason why factors such as BO, job satisfaction, and job stress among healthcare professionals are often studied.

Another issue that has been studied with interest in recent years is work alienation. It is stated in the literature that Karl Marx was the first to use the term "alienation" as a definition. According to Marx, the inability of employees to develop creative abilities leads to their work alienation (Koçoğlu, 2014). Employees who spend most of their time in their workplaces may develop work alienation along with negative attitudes and behaviors due to various factors, and as a result, their relationships with the workplace are damaged, decreasing both the individual and organizational performance (Ertekin & Özmen, 2017). Again, work alienation is associated with many negative consequences, such as organizational citizenship behavior, absenteeism, health problems, anti-productivity behavior, cyberloafing, decreased organizational commitment, decreased work and life satisfaction, and neglect in pursuing common goals of the organization (Yıldız & Şaylıkay, 2014).

It is stated that healthcare professionals differ from other groups due to their stressful work environment and conditions, and therefore they are among the groups most affected by work alienation. Unfortunately, this situation can decrease the quality of the services provided in healthcare organizations and reflect negatively on the care and treatment of patients (Dönmez, 2015). For this reason, it is important for healthcare executives to implement appropriate measures and undertake various initiatives by understanding the effects of work alienation. Empirical evidence is needed for the executives to fulfill these tasks, but there are few studies in the field and there is a need in the literature.

This study focuses on the PQoL and work alienation of healthcare professionals. The aim of this research is (i) to determine the PQoL and work alienation levels of healthcare professionals, (ii) to investigate the relationship between these concepts, and (iii) to reveal personal and professional characteristics that make a significant difference. The conceptual framework created in line with the research goals is given in Figure 1.

Research Questions

1. What are the PQoL and work alienation levels of healthcare professionals?
2. Is there any relationship between the PQoL and work alienation of healthcare professionals?
3. Which characteristics of the participants make significant difference on the PQoL and work alienation levels of healthcare professionals?

Method

Study Design

This is a descriptive, correlational, and cross-sectional study.

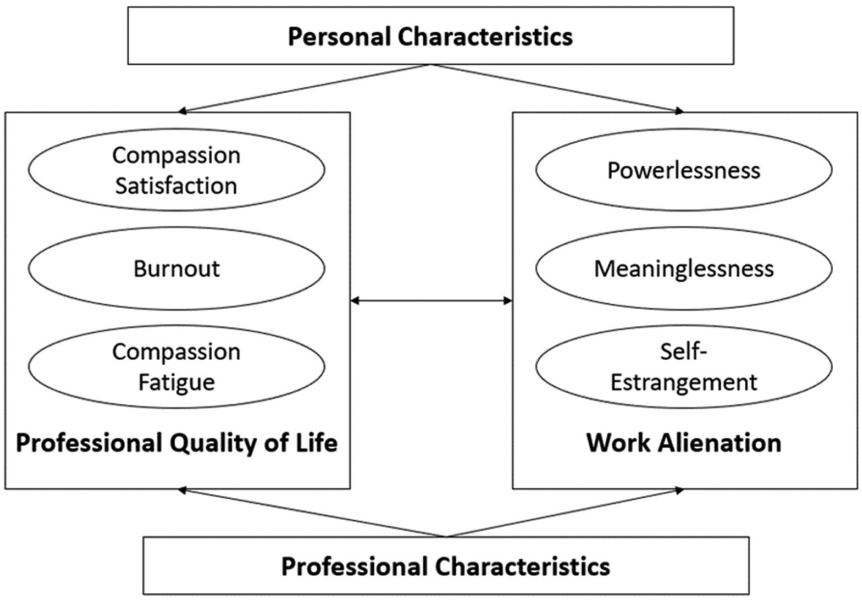

Figure 1.
Conceptual Framework.

Sample

This study was conducted with healthcare professionals working in a private hospital group offering health care services across Turkey, with a total of 31 hospitals in 17 cities. Approximately 4500 healthcare professionals were working in these hospitals and the data collection tool was sent online to all of them. A total of 1523 healthcare professionals (nurses, midwives, paramedics, etc.) working in 27 hospitals in 13 cities belonging to this private hospital group participated voluntarily in the study. The response rate in the study was calculated as 33.8%.

The majority of the healthcare professionals were nurses (75.7%), working in specialized units such as intensive care and emergency (42.8%), and as staff (81.0%). Healthcare professionals in the 19–62 age group (M=26.7; SD=7.6) were mostly female (82.7%), single (68.9%), and graduates of a medical vocational high school (58.9%).

Data Collection

The data of the research were collected in June 2019 by sending an online survey link to healthcare professionals. The online survey consisted of four pages. Informed consent was obtained on the first page by informing healthcare professionals about the purpose of the research and ethical issues. There was the introductory information form on the second page, the PQoL Scale on the third page, and the Work Alienation Scale on the last page.

Introductory Information Form

This form consisted of a total of thirteen questions, including two questions that queried the city and hospital where the participants were employed, and four questions about various personal characteristics such as age, gender, and marital status, and seven questions about professional characteristics such as profession, position, and experience. The questions were selected by the researchers in line with the relevant literature. The two questions on the city and the hospital were not considered for comparison.

Professional Quality of Life (ProQOL) Scale

This scale was developed by Stamm (2005) to determine symptoms of CS, BO, and CF in individuals. The scale consists of 30 items in three subscales. The answers given to the scale items range from "Never-0 points" to "Very often-5 points," and a total of 5 items (item numbers 1, 4, 15, 17 and 29) are reverse scored. A high score from the Compassion Satisfaction (ProQOL_CS) subscale indicates that the respondent has a high level of satisfaction as a helper, and a high score from the Burnout (ProQOL_B) subscale indicates that the respondent experiences a high level of exhaustion. It is recommended that those who score high in the Compassion Fatigue (ProQOL_CF) subscale seek to

receive support or help. The scale was adapted to Turkish by Yeşil et al. (2010), preserving its original structure. The internal consistency coefficients of the Turkish version of the scale vary between .62 and .84 for the subscales, and has a value of α=.85 for the total scale (Yeşil et al., 2010). In this study, it was determined that the internal consistency coefficients of the subscales varied between .76 and .94, and it was α=.92 for the total scale.

Work Alienation Scale (WAS)

The scale has been adapted to Turkish by Sayü (2014) using the scale developed by Mottaz (1981). The scale consists of 3 subscales and 17 items; the three subscales are Powerlessness (WAS_P), Meaninglessness (WAS_M), and Self-Estrangement (WAS_S-E). The answers given to items on the scale range from "Totally Disagree-1 point," to "Totally Agree-5 points," and high scores indicate a high level of alienation. Sayü (2014) reported that the internal consistency coefficient for the subscales varies between .89 and .90 and it is α = .93 for the total scale. In this study, the internal consistency coefficients of the subscales varied between .69 and .78 and it was .88 for the total scale.

Statistical Analysis

The data of the study were analyzed by the IBM SPSS Statistics 20 (IBM SPSS Corp., Armonk, NY, USA) program (licensed by İstanbul University-Cerrahpaşa). While analyzing the data, descriptive statistics (frequency, percentage, minimum–maximum–mean scores, and standard deviation) were used to determine the demographic characteristics and scale scores of healthcare professionals. Correlational analyses (scatter plots and Pearson Moment Correlation) were used to determine the relationships between measurements. Finally, parametric comparative analyses (independent samples *t*-test, one-way ANOVA, and post hoc Tukey HSD) were used to compare measurements by demographic characteristics. Data were analyzed at a 95% confidence interval.

Ethical Considerations

This research is essentially a secondary analysis. The data were collected in June 2019 and the ethics committee of a Istinye University was approached for approval to conduct a retrospective review in April 2020 (Decision No:2020/03-03; Date: 17 March 2020). The manuscript was prepared for publication after obtaining ethical approval. Before the data was collected, written permission was obtained from the hospital group where the research was conducted, the permissions to use the scales were obtained from the authors who adapted the scales to Turkish, and informed consent was obtained from the volunteer healthcare professionals.

Results

The findings of the research will be presented under three headings, in line with the research objectives. the ProQOL and WAS measurements of the healthcare professionals will be presented first, followed by the relationships between measurements, and finally the comparison of measurements by sociodemographic characteristics.

ProQOL and WAS Scores of the Healthcare Professionals

The first aim of the study was to determine the ProQOL and WAS scores of healthcare professionals. As a result of the analysis, the mean ProQOL score of healthcare professionals was determined to be 2.23 (SD=.61) and the highest-scored subscale was ProQOL_CS (M=3.44; SD=1.29). The mean WAS score of healthcare professionals was 2.84 (SD=.29) and the highest-scored subscale was WAS_P (M=2.94; SD=.50; Table 1).

The Relationship Between ProQOL and WAS Scores

Correlation analysis was performed after testing the linearity of the relationship between ProQOL and WAS measurements with scatter plots. This analysis revealed a negative, very weak, and significant relationship (r=–.073; p < .05) between the ProQOL and WAS total scales. The WAS subscale with the highest correlation with the ProQOL total score was WAS_S-E (r=–.257; p < .001). The ProQOL subscale with the highest correlation with the WAS total score was ProQOL_CS (r=–.414; p < .001; Table 1).

The Comparison of ProQOL and WAS Scores

The comparison of the personal characteristics of healthcare professionals revealed that only gender made a significant difference to the ProQOL total score, and women scored higher (p < .05). In addition, no personal characteristics were determined to make a significant difference in ProQOL_CF measurements (p > .05). On the other hand, WAS total

Table 1.
The Relationships Between the ProQOL and WAS (N=1523)

	M(SD)	ProQOL	CS	B	CF	WAS	P	M	S-E
ProQOL	2.23 (.61)	(α=.92)							
CS	3.44 (1.29)	.559***	(α=.94)						
B	1.86 (.75)	.311***	−.531***	(α=.76)					
CF	1.39 (1.03)	.853***	.130***	.487***	(α=.89)				
WAS	2.84 (.29)	−.073*	−.414***	.383***	110***	(α=.88)			
P	2.94 (.50)	.202**	−.070**	.313**	.220***	.559***	(α=.72)		
M	2.84 (.40)	−.074**	−.218***	.135***	.043	.570***	−.036	(α=.78)	
S-E	2.75 (.52)	−.257***	−.461***	.241***	−.056*	.709***	.016	.225***	(α=.69)

Note: *$p < .05$; **$p < .01$; ***$p < .001$.
M = mean; SD = standard deviation; ProQOL = professional quality of life; CS = compassion satisfaction; B = burnout; CF = compassion fatigue; WAS = work alienation scale; P = powerlessness; M = meaninglessness; S-E = self-estrangement.
Cronbach's alpha for coefficients of internal consistency of the measurements are given in parenthesis.

score significantly differed by age group, marital status, and education level-with higher scores of participants who were aged 25 and under, single and medical vocational high school graduates ($p < .05$; $p < .01$). In addition, no personal characteristics made any significant difference to WAS_S-E measurements ($p > .05$; Table 2).

When the healthcare professionals' scores are compared with respect to professional variables, the ProQOL total scores differed significantly by the profession and the working unit ($p < .05$; $p < .01$). Nurses' scores were higher compared to other healthcare professionals; and those working in inpatient services scored higher than those working in specialized units. The professional characteristics that make a significant difference in the WAS total score were determined to be position, professional experience, weekly working hours, working overtime, and working shift ($p < .01$; $p < .001$). According to the results of the analysis, those in the staff position, experienced for 5 years and less, working 46 hours or more per week, working overtime, and working in shifts had higher scores. The comparison of ProQOL and WAS subscales according to the professional characteristics of healthcare professionals is given in Table 3.

The results of the analysis performed in line with the aim of the study are schematically shown in Figure 2.

Discussion

This study was carried out with the aim of determining the PQoL and work alienation levels in healthcare professionals. This is the first study that exploring the relationship between these two variables in the healthcare professionals. Furthermore, this study is valuable as it analyzes the relationship between PQoL and work alienation, which has not been studied before.

ProQOL and WAS Scores of the Healthcare Professionals

Possible scores that can be obtained from ProQOL range from 0 to 6. Taking this score into consideration, although the total score of healthcare professionals participating in the research seems to be low, it is a desired result that the ProQOL_CS score, which is a positive component, is high, while, ProQOL_B and ProQOL_CF scores, which are negative components, are low. In fact, similar to the results of this research, many studies in the literature reported ProQOL_B and ProQOL_CF scores below the average, as well as ProQOL_CS scores above the average (Cohen et al., 2017; Hunsaker et al., 2015; Klein et al., 2018; Merk, 2018; Ruiz-Fernández et al., 2020). The PQoL scores of nurses in studies conducted in Turkey are reported to be at a moderate level (Alan & Yıldırım, 2016). However, especially in studies conducted with healthcare professionals, BO, which has been a subject of interest for many years, and CF, which has begun to attract attention in recent years, are considered as factors that impair the PQoL. Healthcare executives should carefully identify and assist high-risk employees, although they are exceptional. Moreover, the training of health professionals has been shown to increase CS and decrease BO, in the

Table 2.
Comparisions of ProQOL and WAS Scores According to the Personal Characteristics (N=1523)

		ProQOL				WAS			
		Total	CS	B	CF	Total	P	M	S E
	n	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)
Age groups									
≤25 years	968	2.24 (.63)	3.37 (1.32)	1.95 (.74)	1.40 (1.04)	2.86 (.28)	2.99 (.49)	2.83 (.40)	2.75 (.53)
≥26 years	555	2.21 (.58)	3.57 (1.23)	1.70 (.76)	1.37 (1.01)	2.82 (.30)	2.86 (.50)	2.87 (.40)	2.73 (.52)
Test and significance		$t=.733$; $p=.464$	$t=-2.982$; $p=.003^{**}$	$t=6.273$; $p<.001^{***}$	$t=.436$; $p=.663$	$t=2.423$; $p=.016^{*}$	$t=4.971$; $p<.001^{***}$	$t=-1.847$; $p=.065$	$t=.784$; $p=.433$
Gender									
Female	1259	2.25 (.58)	3.52 (1.22)	1.83 (.75)	1.39 (.99)	2.84 (.29)	2.94 (.50)	2.83 (.40)	2.75 (.51)
Male	264	2.14 (.72)	3.05 (1.51)	1.98 (.76)	1.40 (1.17)	2.85 (.30)	2.93 (.50)	2.86 (.38)	2.74 (.56)
Test and significance		$t=2.24$; $p=.025^{*}$	$t=4.810$; $p<.001^{***}$	$t=-2.991$; $p=.003^{**}$	$t=-.094$; $p=.925$	$t=-.200$; $p=.841$	$t=.455$; $p=.649$	$t=-.953$; $p=.341$	$t=-.036$; $p=.971$
Marital status									
Married	473	2.22 (.60)	3.61 (1.25)	1.69 (.73)	1.37 (1.03)	2.82 (.30)	2.87 (.49)	2.85 (.40)	2.73 (.52)
Single	1050	2.23 (.61)	3.36 (1.30)	1.93 (.75)	1.40 (1.03)	2.85 (.29)	2.97 (.50)	2.84 (.40)	2.75 (.52)
Test and significance		$t=-.265$; $p=.791$	$t=3.509$; $p<.001^{***}$	$t=-6.011$; $p<.001^{***}$	$t=-.506$; $p=.613$	$t=-2.422$; $p=.016^{*}$	$t=-3.738$; $p<.001^{***}$	$t=.519$; $p=.604$	$t=-.917$; $p=.359$
Educational Level									
MVHS[a]	897	2.24 (.62)	3.47 (1.24)	1.85 (.75)	1.39 (1.04)	2.86 (.28)	2.96 (.47)	2.88 (.40)	2.75 (.53)
Assoc.[b]	341	2.20 (.61)	3.39 (1.34)	1.85 (.77)	1.35 (1.03)	2.83 (.31)	2.93 (.54)	2.81 (.38)	2.76 (.54)
Gra/postgra.[c]	285	2.25 (.60)	3.42 (1.29)	1.87 (.73)	1.45 (.97)	2.79 (.29)	2.89 (.51)	2.75 (.40)	2.73 (.48)
Test and significance		$F=.720$; $p=.487$	$F=.601$; $p=.549$	$F=.108$; $p=.898$	$F=.817$; $p=.442$	$F=6.642$; $p=.001^{**}$ a > c	$F=2.736$; $p=.065$	$F=11.620$; $p<.001^{***}$ a > b, c	$F=.206$; $p=.814$

Note: $^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$.
M=mean; SD=standard deviation; *t*=independent samples *t*-test; F=one-way ANOVA; ProQOL=professional quality of life; CS=compassion satisfaction; B=burnout; CF=compassion fatigue; WAS=work alienation scale; P=powerlessness; M=meaninglessness; S-E=self-estrangement; MVHS=medical vocational high school; Assoc.=associate degree; Gra/Postgra.=graduate and postgraduate degree.

Table 3.
Comparisons of ProQOL and WAS Scores According to the Professional Characteristics (N=1523)

		ProQOL				WAS			
		Total	CS	B	CF	Total	P	M	S-E
	n	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Profession									
Nurse	1153	2.25 (.61)	3.44 (1.28)	1.89 (.75)	1.42 (1.04)	2.85 (.29)	2.96 (.50)	2.83 (.40)	2.75 (.52)
Others	370	2.17 (.59)	3.46 (1.33)	1.76 (.75)	1.29 (.98)	2.83 (.31)	2.88 (.49)	2.86 (.40)	2.73 (.54)
Test and significance		$t=2.187$; $p=.029^{*}$	$t=-.284$; $p=.777$	$t=2.802$; $p=.005^{**}$	$t=2.204$; $p=.028^{*}$	$t=1.173$; $p=.241$	$t=2.669$; $p=.008^{**}$	$t=-1.281$; $p=.200$	$t=.499$; $p=.618$
Position									
Staff	1233	2.22 (.61)	2.37 (1.29)	1.90 (.75)	1.37 (1.02)	2.86 (.88)	2.98 (.49)	2.84 (.39)	2.76 (.52)
Manager	290	2.28 (.59)	3.74 (1.21)	1.67 (.75)	1.44 (1.05)	2.77 (.31)	2.75 (.48)	2.84 (.43)	2.70 (.52)
Test and significance		$t=-1.869$; $p=.091$	$t=-4.552$; $p<.001^{**}$	$t=4.713$; $p<.001^{***}$	$t=-.995$; $p=.320$	$t=5.054$; $p<.001^{***}$	$t=7.240$; $p<.001^{***}$	$t=-.011$; $p=.991$	$t=1.655$; $p=.098$
Unit									
In-patient[a]	528	2.28 (.64)	3.41 (1.32)	1.91 (.74)	1.51 (1.08)	2.86 (.29)	2.96 (.50)	2.88 (.38)	2.75 (.52)
Special[b]	653	2.17 (.59)	3.34 (1.35)	1.89 (.74)	1.29 (.96)	2.84 (.29)	2.96 (.50)	2.82 (.40)	2.75 (.54)
Polyclinic[c]	342	2.26 (.60)	3.69 (1.09)	1.71 (.77)	1.40 (1.04)	2.81 (.29)	2.88 (.47)	2.82 (.42)	2.74 (.50)
Test and significance		$F=5.121$; $p=.006^{**}$ a > b	$F=8.495$; $p<.001^{***}$ c > a, b	$F=9.154$; $p<.001^{***}$ a, b > c	$F=6.345$; $p=.002^{**}$ a > b	$F=2.842$; $p=.059$	$F=3.501$; $p=.030^{*}$ a, b > c	$F=3.683$; $p=.025^{*}$ a > b, c	$F=.019$; $p=.982$
Professional experience									
≤5 years	904	2.24 (.63)	3.35 (1.32)	1.95 (.73)	1.42 (1.04)	2.86 (.28)	2.99 (.49)	2.83 (.39)	2.75 (.53)
≥6 years	619	2.21 (.58)	3.57 (1.24)	1.72 (.76)	1.35 (1.01)	2.82 (.30)	2.86 (.50)	2.86 (.41)	2.73 (.52)
Test and significance		$t=.939$; $p=.348$	$t=-3.334$; $p=.001^{**}$	$t=6.094$; $p<.001^{***}$	$t=1.362$; $p=.173$	$t=2.745$; $p=.006^{**}$	$t=5.238$; $p<.001^{***}$	$t=-1.428$; $p=.153$	$t=.744$; $p=.457$
Weekly working hours									
≤45 hours	481	2.19 (.57)	3.55 (1.28)	1.70 (.73)	1.32 (.98)	2.81 (.29)	2.88 (.50)	2.85 (.39)	2.71 (.52)
≥46 hours	1042	2.25 (.63)	3.39 (1.29)	1.93 (.75)	1.42 (1.05)	2.86 (.29)	2.97 (.49)	2.84 (.40)	2.76 (.52)
Test and significance		$t=-1.697$; $p=.090$	$t=2.269$; $p=.023^{*}$	$t=-5.488$; $p<.001^{***}$	$t=-1.784$; $p=.075$	$t=-3.005$; $p=.003^{**}$	$t=-3.540$; $p<.001^{***}$	$t=.318$; $p=.750$	$t=-1.920$; $p=.055$
Working overtime									
Yes	1300	2.22 (.61)	3.39 (1.31)	1.88 (.75)	1.38 (1.01)	2.86 (.29)	2.96 (.49)	2.84 (.40)	2.77 (.53)
No	223	2.28 (.62)	3.73 (1.10)	1.69 (.74)	1.43 (1.11)	2.76 (.29)	2.83 (.52)	2.84 (.38)	2.62 (.49)
Test and significance		$t=-1.465$; $p=.143$	$t=-4.058$; $p<.001^{***}$	$t=3.463$; $p=.001^{**}$	$t=-.654$; $p=.513$	$t=4.371$; $p<.001^{***}$	$t=3.653$; $p<.001^{***}$	$t=.116$; $p=.907$	$t=3.755$; $p<.001^{***}$
Working shift									
Shifts	1044	2.21 (.62)	3.31 (1.32)	1.95 (.74)	1.38 (1.02)	2.86 (.29)	3.00 (.49)	2.83 (.39)	2.76 (.53)
Daytime	479	2.27 (.59)	3.73 (1.17)	1.66 (.74)	1.41 (1.05)	2.80 (.30)	2.81 (.47)	2.85 (.42)	2.73 (.51)
Test and significance		$t=-1.591$; $p=.112$	$t=-6.204$; $p<.001^{***}$	$t=7.022$; $p<.001^{***}$	$t=-.547$; $p=.585$	$t=4.290$; $p<.001^{***}$	$t=6.941$; $p<.001^{***}$	$t=-.492$; $p=.623$	$t=1.039$; $p=.299$

Note: $^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$.
M=mean; SD=standard deviation; *t*=independent samples *t*-test; F=one-way ANOVA; ProQOL=professional quality of life; CS=compassion satisfaction; B=burn-out; CF=compassion fatigue; WAS=work alienation scale; P=powerlessness; M=meaninglessness; S-E=self-estrangement.

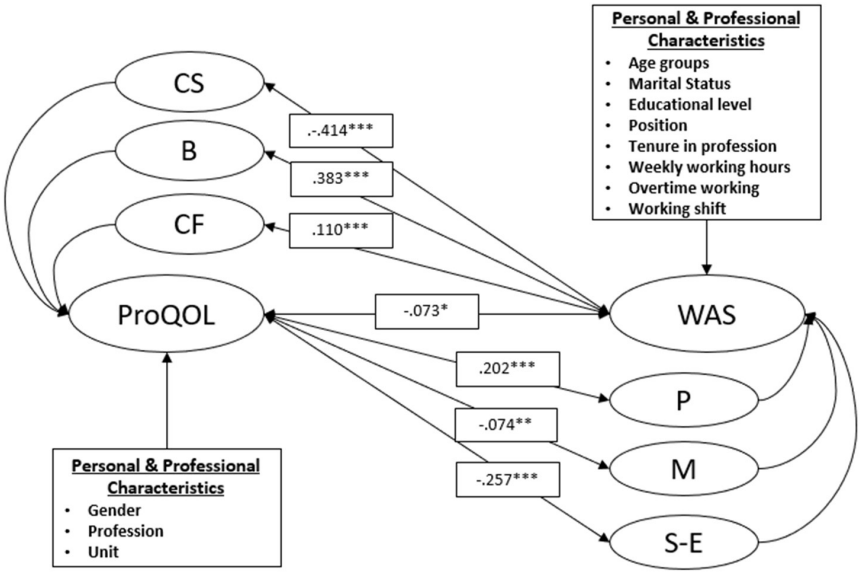

Figure 2.
Study Results According to the Conceptual Framework.

literature (Klein et al., 2018). For this reason, areas of training that will provide health professionals with an increase in their PQoL should be determined. In addition, nurse-led intervention programs applied by Yılmaz et al. 2018, and Dance and Movement Therapy Methods applied by Yılmazer et al. (2020), were effective in decreasing BO and CF scores and increasing CS scores.

Similarly, regarding the WAS, which is the other scale used in the study with possible scores between one and five, it has been determined that healthcare professionals have a score below the average in both the total scale and the subscales. Studies conducted with healthcare professionals in Turkey, mostly including nurses, have reported moderate WAS scores (Ertekin & Özmen, 2017; Kartal, 2018; Koçoğlu, 2014; Özer et al., 2019), while studies with international sampling have reported lower levels of work alienation in healthcare professionals (Amarat et al., 2019). This result can be interpreted as indicating that health care professionals in Turkey are more at risk than their counterparts in other countries in terms of work alienation, although not at a critical level yet. In fact, some studies have reported that work alienation among healthcare staff has increased at an alarming rate, emphasizing this fact (Usul & Atan, 2014). Healthcare executives need to be more closely interested in the phenomenon of work alienation and its consequences, and take initiatives that will make work meaningful for employees.

The Relationship Between ProQOL and WAS Scores

In the research, the hypothesis that employees with a high-level PQoL will experience a lower level of work alienation has been tested, and the relationship has been confirmed, even if not very strong. On the other hand, although the strength of the relationship between the total scores of the two scales was weak, stronger and more meaningful relationships were determined between subscales. Although there is no evidence in this regard in the studies conducted with healthcare professionals in the literature, the results of the study by Erdem (2014) conducted with teachers support a negative relationship. Therefore, it can be suggested that attempts to increase the PQoL may prevent work alienation of healthcare professionals to some extent and contribute to the improvement of organizational outcomes.

The Comparison of ProQOL and WAS Scores

One of the aims of the research was to reveal personal and professional characteristics that make a significant difference in concepts of interest. The results of comparisons reveal that although differing in scale components in total ProQOL measurements, only women, nurses, and those working in inpatient services had significantly higher scores. In other comparisons, however, the differences were not significant. Some studies in the literature indicate that the ProQOL total and ProQOL_CS scores of women are higher (Duarte, 2017; Ruiz-Fernández et al.,

2020), while ProQOL_B and ProQOL_CF scores are low (Ruiz-Fernández et al., 2020). However, it is also possible to come across studies stating that female nurses have lower PQoL (Kızılırmak & Demir, 2016). On the other hand, as an interesting finding, nurses' ProQOL scores were higher compared to those of other healthcare professionals, which may be due to the characteristics of the sample. As a matter of fact, even though nurses face many difficulties and obstacles that affect their PQoL, they have various opportunities as indispensable members of health services. In addition, the professional training and the feeling of satisfaction that they receive in direct patient care can also be effective in this result. The high score of employees in inpatient units who are in direct contact with the patient can also be evaluated in this context.

There are some studies in the literature suggesting that age is an important determinant of PQoL (Hunsaker et al., 2015, Merk, 2018). There are also studies reporting that marital status (Mangoulia et al., 2015), position (Ayaz & Beydağ, 2014), working in shifts (Ayaz & Beydağ, 2014; Ruiz-Fernández et al., 2020), professional experience, and weekly working hours (Hunsaker et al., 2015; Mangoulia et al., 2015; Meyerson et al., 2020) are responsible for significant differences in the PQoL and its components. However, in this study, it was determined that the variables mentioned above did not make a significant difference in the ProQOL total scale, although they were linked to significant differences in the ProQOL components. This may be a result of the positive and negative contributions of the components of ProQOL to the total scale. These opposite effects may have neutralized the differences that the sociodemographic characteristics reveal at the component levels across the total scale. It is suggested that this issue is considered for future research.

The WAS score, which is another concept studied in this work, is observed to differ significantly, with an increased number of personal and professional variables compared to the ProQOL score. Employees who were younger, single, less educated, staff, less experienced, worked longer, worked overtime and in shifts, had higher total WAS scores. There are many studies in the literature that examine the WAS levels of healthcare professionals in terms of various variables such as age, gender, marital status, and education level, and achieve different results (Ertekin & Özmen, 2017; Koçoğlu, 2014; Usul & Atan, 2014). Therefore, it is not possible to draw a common conclusion from these studies, and more research is needed to clarify the relationship of WAS with the personal characteristics of healthcare professionals. On the other hand, researches show that the level of work alienation significantly differs by position (Ertekin & Özmen, 2017) and experience (Koçoğlu, 2014; Usul & Atan, 2014), because managers and those with more professional experience face less work alienation. An increase in self-confidence, career development, participation, and autonomy that accompanies the increase in position and professional experience can be effective in achieving these results.

In conclusion, although there are significant relationships between the personal and professional characteristics of healthcare professionals and the PQoL and work alienation, there are also studies showing the opposite. This situation can vary depending on the culture of organizations and countries. Therefore, more research and evidence-based data are needed to clarify the effect of personal and professional variables on these concepts.

Study Limitations

The main limitation of this study is that it was carried out in private sector hospitals. Thus, in order to generalize the results of the study, it is recommended that the study is repeated in larger samples involving public and university hospitals. As another limitation, the majority of the healthcare professionals who participated in the study are nurses. Therefore, the responses of the professional group of nurses may have been determinative in the results obtained.

Conclusion and Recommendation

As a result of this research, it was determined that the PQoL and work alienation levels of healthcare professionals were slightly below the average, and that there was a very weak and negative relationship between these variables. The results of the research revealed that healthcare executives should take action against the possible work alienation and low PQoL of healthcare professionals. The executives need to identify the factors that have settled in their own organizational culture that are responsible for reducing the PQoL of employees and causing them to be alienated from their work.

In order to improve the PQoL of healthcare professionals, working conditions should be improved so

that they can work more autonomously. In addition, high-quality relationships between managers and colleagues, teamwork, executive support, and workplace social activities should be improved. Moreover, studies in the literature show that the training of health professionals has been shown to increase CS and decrease BO. Therefore, areas of training that will provide health professionals with an increase in their PQoL should be determined. Thus, healthcare managers can improve the PQoL by implementing similar programs in their work environments, and reduce work alienation by giving employees "positions" suitable to their values and beliefs.

Since the relationship between PQoL and work alienation is investigated in this study for the first time, the affecting factors and intermediary relationships between these variables can be investigated by adding more organizational behavior concepts in future studies.

Ethical Committee Approval: The study was approved by the Social and Humanity Sciences Ethical Committee of Istinye University with an approval dated 17 March 2020 and numbered 2020/03-03.

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