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THE EFFECT OF TRANSFORMATIVE POWER OF SUFFERING ON LIFE SATISFACTION ON HOSPITAL WORKERS

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Key Words: Transformative power of suffering, life satisfaction, hospital workers

ABSTRACT

In this study, the level of belief in the presence of the transforming power of suffering and the level of life satisfaction was measured on hospital workers working at Isparta City Hospital and Süleyman Demirel University Research and Practice Hospital. The purpose of this study was to determine the effects of the transformative power of suffering on the life satisfaction levels of hospital workers. The universe of the research was composed of employees of Isparta City Hospital and Süleyman Demirel University Research and Practice Hospital. Within the scope of the research, a questionnaire was applied to 287 hospital employees (physician, nurse / midwife, other health personnel, administrative personnel and other personnel). As a data collection tool, "Transformative Power of Suffering Scale" adapted from Turkish by Dinçer et al (2015) prepared by Joshanloo (2014) which is composed of 5 expressions and "Life Satisfaction Scale" adapted from Turkish by Dağlı and Baysal (2016) prepared by Diener et al., (1985) which is composed of 5 expressions, was used. As a result of the research, it has been revealed that hospital employees have a belief in the transformative power of suffering, which has a positive influence on the life satisfaction of hospital workers.

Key Words: Transformative power of suffering, life satisfaction, hospital workers.

LIFE SATISFACTION

Life satisfaction is one of the most important indicators of well-being of individuals (Koivumaa et al., 2001: 433; Erdogan et al., 2012: 1038-1039). While subjective well-being is defined as individuals' cognitive and emotional evaluation of their lives; life satisfaction forms the cognitive dimension of the subjective well-being (Diener et al., 1985: 71; Diener and Lucas, 1999: 277). Life satisfaction is the situation or the attitude that the individuals get when they make evaluations towards their whole lives (Dikmen, 1995: 118; Dost, 2007: 133). Life satisfaction describes a cognitive process where the individuals compare the life standards with the standards defined by themselves. At the end of the comparison of personal goals and objectives with life standards, if the life standards comply with mentioned goals and objectives, it can be said that the life satisfaction of that individual is high. As it is seen, life satisfaction describes a cognitive and judicatory process where individuals

evaluate their lives according to their own criteria (Diener et al., 1985: 71; Pavot et al., 1991: 150; Pavot and Diener, 1993: 102; Koivumaa et al., 2001: 433).

Researchers address life satisfaction via two approaches; top-to-bottom approach and bottom-up approach. In the top-to-bottom approach life satisfaction is explained as permanent features like personal characteristics, while in the bottom-up approach many fields in the life of an individual (like working life, family, health etc.) are explained by correlating with life satisfaction (Erdogan et al., 2012: 1040-1041; Itzhaki et al., 2015: 404). Namely, personal characteristics of individuals are handled in the top-to-bottom approach of life satisfaction, while fields from the lives of individuals are handled in the bottom-up approach (Erdogan et al., 2012: 1042). Life satisfaction is related with numerous fields of individuals' lives. Factors like psychiatric problems of individuals, social support taken, life conditions etc. may have an effect on life satisfaction (Koivumaa et al., 2001: 433). Besides, increased life satisfaction decreases death rates, helps reduce sleep complaints, and moreover it minimizes the absenteeism inclination of the workers so that it increases their working performances and motivations (Erdogan et al., 2012: 1038-1039).

TRANSFORMATIVE POWER OF SUFFERING

"Was mich nicht umbringt, macht mich stärker" Friedrich Nietzsche

Nietzsche's above mentioned saying "What does not kill me, makes me stronger" forms the basis of the transformative power of the suffering. Individuals can be exposed to many traumatic events that are experienced by themselves or happened around them. Tedeshchi and Calhoun (1995: 16) report that numerous people suffer great pain all over the world caused by witnessing the losing of one's life around them, experiencing traumatic events, natural disasters' destructive effects on the public, and contagious diseases that threat humankind etc.

When individuals experience a traumatic event, or expose to a suffering, firstly the adverse effects of that event come to mind. Calhoun and Tedeshi (1999: 5-10) indicated that, unwanted results like having psychological/behavioral disorders, or having a pessimistic mood and mind may arise at the end of such events that individuals experience. However, when the studies examined (Collicut and Linley, 2006; Peterson et al., 2008; Holgersen et al., 2010), it is seen that such events may also have positive effects on individuals as they can have negative effects (Calhoun and Tedeshi, 1999: 10-11; Calhoun and Tedeshi, 2001: 157-158). The perception of the traumatic events, suffering, and sorrow can differ according to the individuals and their cultures (Eid and Diener, 2001: 869; Joshanloo, 2014: 141). While suffering pain is correlated with results that cause displeasure in the Western culture, it can be correlated with positive results in some cultures. In some cultures it is believed that suffering pain helps individuals get mature and develop, and take the individual to happiness and goodness. In terms of the transformative power of the suffering, at the end of some traumatic, suffering experiences of the individuals, there is a belief that the suffering has a positive transformative power (Joshanloo, 2014: 140, Joshanloo, 2013: 1857; Wong; 2012: 13). World religions (Christianity, Islam, Hinduism, Buddhism etc.) point that good results will come after sufferings Besides, social scientists, philosophers, and some traditions also points out that individuals can have a positive change after big sufferings (Calhoun and Tedeshi, 1999: 10-11; Calhoun and Tedeshi, 2001: 157-158). At the end of the suffering and traumatic event, individuals can experience positive personal transformations like positive psychological changes, being more

sympathetic by applying empathy more often in interpersonal relations, increased self-reliance, enhanced sense of mercy, and psychological development (Tedeshchi and Calhoun, 1995; Tedeschi et al., 1998: 10-14; Calhoun and Tedeshi, 2001: 159-160).

Traumatic events (experienced sufferings), affect the individual that is exposed and his/her family, relatives and witnesses, the healthcare staff that treat the individual, the workers that witness the event in the hospital etc., and affects individuals that indirectly exposed to the event (Yılmaz, 20206: 10). Raphael et all (1984)'s study on the recovery workers after the railway tragedy took place in Australia, and in the study of McFarlane (1988) on the firefighters worked in the forest fire took place in Australia, it is revealed that the recovery workers of the tragic calamities are also affected psychologically (Weiss et al., 1995: 361). While the studies in this area have focused on the transformation and changes in the lives of the individuals that are exposed to the (trauma) suffering (Tedeschi and Calhoun, 1996; Tedeschi and Calhoun, 2004; Kardaş, 2013; Doğan, 2015), this study will examine the transformational power of the suffering, on the hospital workers who are unavoidably exposed to the sufferings of the patients by providing healthcare. Additionally, it is going to be examined how the belief of the hospital workers about the transformational power of suffering has an effect on the life satisfaction of the workers.

MATERIALS AND METHOD

Objective

This study aims to measure the level of belief in the presence of the transforming power of suffering and the level of life satisfaction of the workers of the Isparta City Hospital and Süleyman Demirel University Research and Practice Hospital; in that regard, to determine the effects of the transformative power of suffering on the life satisfaction levels of the workers.

The Universe and Sample

The universe of the research is composed of employees of Isparta City Hospital and Süleyman Demirel University Research and Practice Hospital. The questionnaire was applied to physicians, nurses / midwives, other health personnel, administrative personnel and other personnel. Necessary permissions were taken from the hospitals for the study 287 questionnaires were collected with the convenience sampling method, and the questionnaires collected were taken into consideration.

Data Collection Tool

As a data collection tool, "Transformative Power of Suffering Scale" adapted from Turkish by Dinçer et al. (2015) prepared by Joshanloo (2014) which is composed of 5 expressions and "Life Satisfaction Scale" adapted from Turkish by Dağlı and Baysal (2016) prepared by Diener et al., (1985) which is composed of 5 expressions, was used in the research. The scales are unidimensional. Likert type scale was used in the data collection tool, the level of agreement of the questionnaire participants is scaled from "1" if the participant totally disagrees to "5" if the participant totally agrees. At the end of the questionnaire were the demographic questions.

Analysis Method

The data obtained from the questionnaire forms was transferred to the computer with the help of Statistical Package for the Social Sciences (SPSS) program and the analysis of the data was made with SPSS as well. Frequency and percentage calculations were made for the questions related with descriptor information and qualitative variables. In the questionnaire, statistical evaluations were made depending on the arithmetic average and standard deviation calculations of the statements that are in the realms of life

satisfaction and the transformative power of the suffering.

The data was subject to test of normality, and kurtosis-skewness values of each dimension were procured. At the end of this evaluation, the test statistic values of the life satisfaction dimension and transformative power of suffering dimension, were observed in between -1.96 and +1.96. It was clearly understood that the dimensions were in normal distribution (Can, 2014: 85). Accordingly, parametric tests were used in the comparison of the dimensions with regards to demographic variables. One of the parametric tests, 'significance test of the gap in between two averages (T-test)' was used in the comparison of the dual groups, while one of the parametric tests, 'analysis of variance (ANOVA) (F-test)' was used in the comparisons of three or more groups. At the end of the analysis of variance, when there found a gap in between the groups, 'Turkey's-b test' was used to locate the source of the gap. Moreover, regression analysis was made to determine the effect of the transformative power of the suffering on the life satisfaction levels of the hospital workers.

RESULTS

Within the scope of the research, the distributions of the hospital workers according to various independent variables are shown in Table-1.

Tablo 1. Demographic Characteristics of Hospital Workers

Variables	**Frequency**	**%**
Gender		
Male	117	40.9
Female	169	59.1
Marital Status		
Married	199	69.8
Single	86	30.2
Age (Year)		
29≤	77	27.7
30-39	97	34.9
≥40	104	37.4
Role		
Physician	45	15.7
Nurse / Midwive	81	28.3
Other Health Personnel	74	25.9
Administrative Personnel	64	22.4
Other	22	7.7
Education Level		
Elementary/High School	40	14
Pre-license	74	25.9
License	130	45.5
Postgraduate	42	14.7
Income (TL)		
1999≤	63	25.7
2000-2999	38	15.5
3000-3999	106	43.3
≥4000	38	15.5
Total Working Years		

0-9	98	35.9
10-19	91	33.3
≥20	84	30.8
Hospital		
City Hospital	161	56.1
University Hospital	126	43.9
Total	**287**	**100**

As seen on the Table-1, %27.7 of the research participants are 29 years old or under, %34.9 were in between 30 and 39, and %37.4 were 40 or over. %40.9 of the participants were male while %59.1 were females. With regards to marital status, more than half of the hospital workers (% 69.8) were married. When the educational status of the participants were examined, it was found that quite a few of them (%45.5) have license degree.

With regards to the role distribution of the hospital workers, %15.7 of the participants were physicians, %28.3 of them were nurses / midwives, %25.9 were other health personnel, %22.4 were administrative personnel and %7.7 were other personnel. From the point of income status, %25.7 of the participants have an income of 1999 TL and under, %15.5 of them have an income in between 2000-2999 TL, %43.3 of them in between 3000-3999 TL, and %15.5 of them have an income 4000 TL and over.

When the total working years of the questionnaire participants were examined, %34.1 of them were observed to have experience less than 9 years, while %33.3 of them have working experience in between 10-19 years, and the rest of them (%30.8) have experience over 20 years. Lastly, it was observed that %56.1 of the participants were from the City Hospital while %43.9 of them were from the University Hospital.

Tablo 2. Distribution of the Points That Hospital Employees Receive from Expressions of Life Satisfaction

No	**Expressions**	$\overline{X}$	**SD**
1	In most ways my life is close to my ideal.	2.91	1.046
2	The conditions of my life are excellent.	2.78	0.926
3	I am satisfied with my life.	3.37	1.040
4	So far I have gotten the important things I want in life.	3.33	1.045
5	If I could live my life over, I would change almost nothing.	2.57	1.255

The distribution of standard deviation and arithmetic average of each statement in the Life Satisfaction Questionnaire were shown on Table-2. When examined, the statement that was fourth among the cultural communication statements, *"I have possessed important things that I wanted from life until now."* had the highest agreement level (3.33) among the hospital workers.

When the averages related with the statements were generally examined, the averages on 3.00 or over point out that the individuals are inclined to agree. In this context, it is obviously seen that the individuals are inclined to agree with statements 3 and 4, which have averages

over 3.00. The other statements have averages that are close to 3.00. On that point it is going to be mentioned that, the life satisfaction of the hospital workers is on a medium level. Besides, the statement that has the least agreement average among the other statements is "I would change almost nothing in my life if I came into the world again.", from which it is understood that, if the hospital workers have the opportunity they may want to make some changes in their lives while they are happy with their lives in medium level.

Tablo 3. Distribution of the Points That Hospital Employees Receive from Expressions of Transformative Power of Suffering

No	Expressions	$\overline{X}$	**SD**
6	Sometimes sadness and suffering can lead us to happiness.	3.26	1.241
7	Sadness can be a transcendent state with some benefits for one's ultimate perfection and happiness.	2.99	1.199
8	It is necessary to go through sadness, hardship, and misfortune to achieve happiness.	3.49	1.220
9	Without sadness and suffering one cannot become perfect.	3.40	1.294
10	If suffering is taken with patience and gratitude, it gets converted to happiness.	3.72	1.230

The distribution of standard deviation and arithmetic average of each statement in the Transformative Power of Suffering Questionnaire were shown on Table-2. When examined, it is understood that the statements have an average over 3.00 except number 7. From that point, it is understood that, the workers of the hospitals of the research have a strong belief in that the suffering experiences serve to positive personal changes (Dinçer et al., 2015: 413).

Tablo 4. Psychometric Properties of Life Satisfaction Dimension and Transformative Power of Suffering Dimension

Dimensions	**Number of Expression**	**Max/ Min**	**Cronbach Alpha**	$\overline{X}$	**SD**
Life Satisfaction	5	1-5	0.813	2.988	0.808
Transformative Power of Suffering	5	1-5	0.817	3.374	0.936

Cronbach Alpha parameters were calculated to measure the reliability of the dimensions in the research, and CronbachAlpha of the two dimensions were calculated over 0.70. The points that the hospital workers got from life satisfaction dimension were under 3.00, while the points from the transformative power of the suffering have an average over 3.00. From that point, the hospital workers had a mediocre inclination to life satisfaction with an average of 2.988 that is close to 3.00, while the percentage of agreement to the idea that the sufferings helps personality development was found to be in a higher level.

Tablo 5. Comparison of Life Satisfaction Dimension According to Demographic Variables

Variables	n	$\overline{X}$	SD	Test Value	p
Gender					
Male	117	2.890	0.799	t=-1.717	0.087
Female	169	3.056	0.812		
Marital Status					
Married	199	2.991	0.792	t=-0.113	0.910
Single	86	2.979	0.858		
Age					
29≤	77	2.976	0.787	F=0.911	0.403
30-39	97	3.071	0.842		
≥40	104	2.917	0.807		
Role					
Physician	45	2.840	0.839	F=2.416	0.049
Nurse / Midwive	81	3.054	0.797		
Other Health Personnel	74	3.141	0.773		
Administrative Personnel	64	2.950	0.768		
Other	22	2.618	0.915		
Education Level					
Elementary/High School	40	2.828	0.962	F=2.768	0.042
Pre-license	74	3.207	0.690		
License	130	2.911	0.802		
Postgraduate	42	2.995	0.819		
Income (TL)					
1999≤	63	2.948	0.821	F=3.063	0.029
2000-2999	38	2.694	0.857		
3000-3999	106	3.139	0.772		
≥4000	38	2.936	0.789		
Total Working Years					
0-9	98	3.042	0.771	F=0.422	0.656
10-19	91	2.959	0.848		
≥20	84	2.938	0.811		
Hospital					
City Hospital	161	2.951	0.841	t=-0.879	0.380
University Hospital	125	3.036	0.767		

When the participants were compared according to the income groups in terms of life satisfaction dimension points, it was found out that there was a statistically significant difference in between the groups (F=3.063, p=0.029). In further analysis the difference was located to stem from the lower life satisfaction level of the workers in 2000-2999 TL level than the workers in 3000-3999 level.

When the life satisfaction dimension was compared with educational status (F=2.768, p=0.042) of the hospital workers, it was found out that there was a statistically significant difference. In further analysis the difference was located to stem from relatively lower life satisfaction level of the elementary/high school graduate workers, than the workers with license and postgraduate degrees. From this point, it can be conferred that the life satisfaction level of the workers generally increases as the educational status gets higher. Besides,

when the comparisons related with the role distribution were examined, it was observed that there was a statistically significant difference (F=2.416, p=0.049). It was understood that the difference originated from the higher level of life satisfaction of the other health personnel, than the other personnel. No significant difference was located among the other variables.

Tablo 6. Comparison of Transformative Power of Suffering Dimension According to Demographic Variables

Variables	n	$\overline{X}$	SD	Test Value	p
Gender					
Male	117	3.294	1.006	t=-1.236	0.218
Female	169	3.433	0.884		
Marital Status					
Married	199	3.354	0.911	t=-0.515	0.283
Single	86	3.416	0.997		
Age					
29≤	77	3.451	0.948	F=0.441	0.644
30-39	97	3.343	0.965		
≥40	104	3.325	0.927		
Role					
Physician	45	3.164	0.956	F=1.160	0.329
Nurse / Midwive	81	3.362	0.869		
Other Health Personnel	74	3.473	1.009		
Administrative Personnel	64	3.477	0.886		
Other	22	3.373	1.021		
Education Level					
Elementary/High School	40	3.661	0.987	F=2.884	0.036
Pre-license	74	3.503	0.842		
License	130	3.285	0.988		
Postgraduate	42	3.161	0.808		
Income (TL)					
1999≤	63	3.480	1.039	F=1.472	0.223
2000-2999	38	3.092	1.091		
3000-3999	106	3.409	0.898		
≥4000	38	3.310	0.770		
Total Working Years					
0-9	98	3.338	0.882	F=0.633	0.532
10-19	91	3.454	1.006		
≥20	84	3.303	0.928		
Hospital					
City Hospital	161	3.350	0.946	t=-0.537	0.592
University Hospital	125	3.410	0.926		

When the participants were compared according to the educational status in terms of the transformative power of suffering dimension points, it was found out that there was a statistically significant difference in between the groups (F=2.884, p=0.036). In further analysis the difference was located to stem from the lower points of the workers with license or postgraduate degrees, than the elementary/high school graduate workers. It is understood that the more educated the hospital workers, the less

they agree with the idea that the sufferings helps individuals mature and positively affect personality development. No significant difference was located among the other variables.

Tablo 7. Analysis of the Effect of Transformative Power of Suffering on Life Satisfaction

Independent variable	Dependent variable	R	R^2	F	p	ß	t	p
Transformative Power of Suffering	Life Satisfaction	0.357	0.127	41.521	0.000	0.357	6.444	0.000

At the end of the regression analysis, %12 of (R^2=0.340) the change in the variable of the life satisfaction is explained with the transformative power of the suffering. Moreover, it was seen that there was no problem with regards to the significance of the expressive power of the model (F=41.521, p=0.000). At the end of regression analysis it was found that the transformative power dimension (β=0.357, t=6.444, p=0.000), which was handled as the independent variable, had a positive effect on the life satisfaction dimension, and that the effect was statistically significant. From that point, it can be mentioned that the more the hospital workers have the belief in the transformative power of the suffering, the more the level of the life satisfaction inclined to increase.

DISCUSSION AND CONCLUSION

At the end of the research, it was determined that women compared to men, married ones compared to singles, and University Hospital workers compared to City Hospital workers have higher levels of life satisfaction. Similarly, in the research on the physicians by Ünal et al (2001) it was found out that women compared to men, and married ones compared to singles have higher levels of life satisfaction. The research about examining the effects of life satisfaction on suicide risk by Koivumaa-Honkanen et al (2001) suggested that among the participants, men compared to women have higher levels of life satisfaction. Besides, it was seen that there was an inverse proportion in between total working years and life satisfaction. The other health personnel have the highest life satisfaction level. It should be added that, there are several factors like; being newly transferred to Isparta City Hospitals, having more intensive work hours than before, having a dual-executive administration (private+government) structure, that are affecting the life satisfaction level of the University Hospital workers being more than the City Hospital workers.

It was found out that, among the participants, women compared to men, singles compared to married ones, and University Hospital workers compared to City Hospital workers, have a higher level of belief that the suffering experiences in their lives have returned as personal gaining, and those had been critical factors towards bliss. Moreover, while the belief in the transformative power of suffering and oldness have an inverse proportion, it was identified that it was the same for the education level. In other words, the younger hospital workers concede that the suffering has positive effects on individuals than the older workers do. At the same time, the higher the hospital workers have education level, the lower they have belief in the transformative power of suffering. The group with the highest level of belief in that suffering renders an individual powerful and it is a factor that brings to bliss, is composed of administrative personnel.

The universe of this research is composed of the hospital workers. The starting point of this was the thought among the hospital workers that the transformative power of suffering was a critical criterion. In other words, the hospital workers undergo suffering or traumatic experiences

in their own lives, moreover they also have to expose to traumatic cases and have to see these cases in the line of their jobs. The hospital workers' having to expose to such cases, can positively or negatively affect their perception about suffering, and may change the results of the suffering on themselves. At the end of the research, it is seen that the average of the workers is over 3.00 (3.374) with regards to the transformative power of suffering dimension. It is understood that the workers believe in that traumatic experiences that they expose both in their own lives and in daily hospital activities, will create positive results and contribute to their personal development. The hospital workers believe that at the end of such suffering experiences, they will turn into more merciful individuals, and will be able to reach to the bliss.

At the end of the research it was proved that, the hospital workers' belief in the transformative power of suffering is effective on their life satisfaction levels. Together with the belief in the transformative power of the suffering, their levels of life satisfaction show an increase; in other words, the transformative power of suffering has a positive effect on the life satisfaction level. Similarly, in the study of Dinçer et al (2015) on students, it was put forth that there was a statistically significant positive relation in between transformative power of suffering and life satisfaction. In their research, Linley and Joseph (2011) showed that there was a relation in between meaning of the life and growth after trauma. Besides, Tripplet et al (2012) has put forth that there was an inverse proportion in between the life satisfaction, the meaning of life, and the growth after trauma. It is understood from here that there is a relation in between life satisfaction, the transformative power of suffering, and individual's positive growth after trauma. However, this relation can change according to the sample that these researches applied. This is because of different interpretation of suffering among different individuals and cultures. In Islam, it is believed that calamities, bad happenings, and illnesses come from the God, and there is a belief that if the individual patiently bears that burden, the volition of God will take place. Individuals believe that at the end of sufferings, they will reach peace and bliss (Jashanloo, 2014: 1864). On the other hand, in the study of Tripplet et al (2012) on the students of a university in America, it was found out that there was an inverse proportion in between life satisfaction and transformative power of suffering. However, the study of Dinçer et al (2015) on Turkish students, and our study on Turkish hospital workers, have proved a positive relation in between life satisfaction and transformative power of suffering. It is because of the fact that the sample groups are from different cultures, different religious perspectives, that is why the approach towards suffering and interpretation of the results of suffering are diversified.

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JOURNAL OF INTERNATIONAL HEALTH SCIENCES AND MANAGEMENT

A STUDY ON ORGANIZATIONAL COMMITMENT OF THE WORKERS IN A PUBLIC HOSPITAL IN KONYA

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Abstract

This research was conducted to determine the organizational commitment of hospital employees. The research was applied to health workers working in a state hospital in Konya. The sample of the research consists of 150 people. In the research, face-to-face survey method was applied using quantitative research design. In this research used the organizational commitment scale developed by Meyer Allen Smith and Kaya's (2007) used this scale in his master's thesis. The scale consists of 3 dimensions. The scale was prepared in likert style and a 5-point system was used ranging from "I strongly agree" to "I absolutely disagree". The answers from the participants were collected and transferred to the computer environment and analyzed by the SPPS program. The validity of the scale was calculated and the cronbach alpha value was found to be 0.885. The scale of this result frame is reliable. As a result of the research, it was observed that gender, age and marital status did not affect organizational commitment. From an educational standpoint, the organizational commitment of graduate alumni is lower. The medical secretaries' organizational commitment was higher than the cleaning staff.

Introduction

The description, size, relation with similar notions of organizational commitment are comprehensive and contradictive topics. The researchers described with regards to their own concerns. According to Buchanan (1974), organizational commitment is an interest in organization. Lee (1971) describes organizational commitment as consolidation with organization. According to McCaul et. al (1985), organizational commitment is the emotional and valuation reaction towards the organization, a large scale attitude which employees have towards organization (Yousef, 2003:1068). Guatam et al. also state that organizational commitment is a psychological situation determining employees' relation with organization and it points out the commitment to the whole of the organization.

In the first studies conducted about organizational commitment, it was described as adopting organization's aims and values, showing efforts to become a part of the organization, and feeling like a member of a strong family (Steers, 1977:46). The performance of the individuals committed to their organizations would be high. Their absenteeism would decrease, and it would lead such rates of being late, leaving work to decrease (Mathieu and Zajac, 1990:171-172). High commitment would increase customers' satisfaction (Üner et al. 1988) and within this context, it would be a significant supporter of total quality management. It was proved in the studies that the most important sign of organizational citizenship attitude was organizational commitment (Kaufman et al, 2001: 436-450; Schappe, 1998:277-290).

The idea that the employees committed to organizations would make more effort for organizational development and thus, both the organization and employees would be more successful and this would affect the product's or service's quality in a positive way was proved by other authors, too (İlsev, 1997) (Nelson and Quick JC, 1997:109-110). By contrast with this, it's stated that low level of commitment to organization would lead to negative situations such as productivity, job unsatisfaction, absenteeism, being late to work, leaving work and that's why, organizational commitment is firstly checked in guessing unexpected situations and employee's leaving work (Jalonen et al. 2006: 268-276, Grusky, 1966: 488-503).

The aim of this study is to investigate organizational commitment of healthcare staff. The research was carried out in a state hospital serving in Konya.

Metod

This research was conducted to determine organizational commitment level of the hospital staff. The research was performed on the healthcare staff serving in a state hospital. Research sample consists of 150 individuals. In the research, quantitative research design was utilized and face to face survey method was used.

The population of the research consists of 150 individuals. The research scale; organizational commitment scale developed by Meyer Allen Smith and Kaya used in his master's thesis (2007) was used. The scale consists of 3 dimensions. The scale was prepared in Likert style and 5 point system from "strongly agree" to "strongly disagree" was used. The answers obtained from participants were gathered and transferred into electronic environment and analyzed in SPSS program. The validity of the scale was calculated and its cronbah alpha value was founded as 0,885. Within this result, the scale was found reliable.

Findings And Analyzes

Table 1. Socio-demographic data of healthcare staff participating in the research

How old are you	N	%	Educational Status	N	%
Under 25 years old	54	36	Primary School	8	5,3
25 to 30 years old	34	22,7	High School	40	26,7
30-40 yaş	38	25,3	Associate degree	51	34
40 years old and older	24	16	Bachelor's degree	44	29,3
Gender	N	%	Master's degree	7	4,7
Female	66	44	Position	N	%
Male	84	56	Healthcare staff	72	48
Marital Status	N	%	Medical Secretary	23	15,3
Single	70	46,7	Cleaning staff	13	8,7
Married	80	53,3	Security	3	2
Experience year	N	%	Administrative Affairs	39	26
Less than 1 year	16	10,7	Experience in the organization	N	%
1 to 5 years	69	46	Less than 1 year	13	8,7
5 to 10 years	49	32,7	1 to 5 years	80	53,3
More than 10 years	16	10,7	5 to 10 years	49	32,7
Experience in health sector	N	%	More than 10 years	8	5,3
Less than 1 year	11	7,3	Total	150	100
1 to 5 years	65	43,3			
5 to 10 years	40	26,7			
More than 10 years	34	22,7			
Total	150	100			

Examining Table 1, we can see that 36% of participants consist of staff under age of 25. 56% of the staff are male and 53.3% of them are married. 29.3% of them have Bachelor's degree and they constitute the majority. 48% of the staff consist of healthcare staff and 32.7% of them consist of the ones having experience between 5 to 10 years. 53.3% of participants consist of the ones working for 1 to 5 years.

Table 2. Analyzes related to socio-demographic features of the staff participating in the research (T-test in independent samples and one way analysis of variance)

		N	$\bar{x}$	F/t	p
Gender	Female	66	3,25	-0,641	0,522
	Male	84	3,31		
Marital status	Married	70	3,26	-0,430	0,674
	Single	80	3,30		
Age	Under 25 years old	54	3,27	0,034	0,992
	25 to 30 years old	34	3,31		
	30 to 40 years old	38	3,28		
	Older than 40 years old	24	3,30		
Educational status	Primary School	8	3,12	3,373	0,011
	High School	40	3,18		
	Associate degree	51	3,51		
	Bachelor's degree	44	3,20		
	Master's degree	7	2,99		
Position	Healthcare staff	72	3,21	3,925	0,005
	Medical secretary	23	3,67		
	Cleaning Staff	13	3,00		
	Security	3	3,44		
	Administrative Affairs	39	3,29		
Time of experience	Less than 1 year	16	3,26	0,593	0,620
	1 to 5 years	69	3,25		
	5 to 10 years	49	3,37		
	More than 10 years	16	3,19		
Time of experience in the organization	Less than 1 year	13	3,16	2,633	0,520
	1 to 5 years	80	3,20		
	5 to 10 years	49	3,39		
	More than 10 years	8	3,71		
Time of experience in health sector	Less than 1 year	11	3,15	1,218	0,306
	1 to 5 years	65	3,23		
	5 to 10 years	40	3,43		
	10 years and more	34	3,27		

Examining Table 2, T-test analyze was performed in order to test the difference between organizational commitment and marital status and gender of staff participating in the research and any significant difference couldn't be detected ($p>0,05$). Analysis of variance was performed in order to test the difference between organizational commitment and age of staff and any significant difference couldn't be detected ($p>0,05$).

Analysis of variance was practiced in order to test organizational commitment and educational status of staff. Significant difference was detected between organizational commitment and educational status of the staff ($p<0,05$). Scheffe test was practiced with the aim of testing in which variables the difference existed, and it was determined that those who had Master's degree had less organizational commitment than others.

Analysis or variance was practiced in order to test organizational commitment and position of staff and significant difference was detected ($p<0,05$). To be able to test in which variables the difference existed, Games-Howell test was practiced. It was observed that there was difference in organizational commitment of healthcare staff and security ($p<0,05$) and it was determined that organizational commitment of security was higher. According to same test's results, difference was detected between cleaning staff and secretaries ($p<0,05$) and medical secretaries' organizational commitment was higher. Variance analysis was practiced to test the difference among years of experience of the employees, years of experience in the

organization and years of experience in health sector, and significant difference wasn't detected.

Discussion and Conclusion

In this study which was conducted with the aim of determining hospital staff's organizational commitment, examining staff's socio-demographic features; Most of the participants (36%) consist of the ones younger than age of 25. Examining with regards to educational status, most of them consist of graduates of high school and Bachelor's degree (26.7% and 29.3%). Examining with regards to gender, 56% of them consist of males and 53.3% of them are married. Examining staff's positions, most of them (48%) consist of healthcare staff. With regard to experience, it was determined that most of them had been working for 1 to 5 years and 5 to 10 years (46% and 32.7%). In view of experience in the organization, it was determined that most of them had been working for 1 to 5 years and 5 to 10 years (53,3% and 32.7%). In view of experience in health sector, 43.3% of them had been working for 1 to 5 years, 26.7% of them had been working for 5 to 10 years and 22.7% of them had been working for more than 10 years.

Examining analysis related to research, any significant difference couldn't be detected between organizational commitment and gender of the participants. It was detected that organizational commitment of females ($\bar{x}$:3,25) and males ($\bar{x}$:3,31) was more than average. Examining organizational commitment with regards to marital status, it was determined that being married or single didn't have effect on organizational commitment. It was determined that married ($\bar{x}$:3,26) and single ($\bar{x}$:3,30) ones had organizational commitment more than average. Examining with regards to ages of the staff, it was determined that organizational commitment wasn't related to age and all age groups were over the average. Examining with regards to educational status, it was determined that the average of organizational commitment of the ones studying Master's ($\bar{x}$:2,99) degree was low. In accordance with this result, it's thought that the ones studying Master's degree have more expectations from organizations. Examining with regards to positions, it was determined that security staff ($\bar{x}$:3,44) had more organizational commitment than healthcare staff ($\bar{x}$:3,21). The reason of this is thought to be healthcare staff's workload and this leads to lower organizational commitment. With regards to positions, organizational commitment of medical secretaries ($\bar{x}$:3,67) is more than organizational commitment of cleaning staff ($\bar{x}$:3,00). In accordance with this result, it's thought that the fact that cleaning staff work intenser affect their commitment. Examining with regards to year of experience, year of experience in the organization, and year of experience in health sector, it was determined that organizational commitment was more than average among all years.

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Opening of Spiritual Support Units in Hospitals and Investigation of the Issue According to Islamic Law

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ABSTRACT:

The spiritual education which seems to be heavy and tough, but which is beneficial to the person in hand, gives the person consciousness and peace. Performing spiritual therapy, giving morale to patients and their relatives, contr ibuting to religious education, chatting with them and answering their questions, meeting religious needs, facilitating prayer and worship, and such similar methods and practices have undoubtedly taken its place from the earliest works of art in Islamic sources. We find the first examples of this service among behaviors of the Prophet Muhammad (Peace be upon him). This issue applied in a frame of interviewing sessions with patients and their relatives that are special field of expertise and practiced in European countries. It is known that this practice has been tried especially in a few hospitals selected from certain regions in our country and that some new methods and regulations are required to be passed on. The material investments to be made by the official institutions, especially in the fields of health and theology, will eventually return to the people and the social life in a positive way.

These services, of course can be fulfilled with a faithful, loyal and devoted imam who is always well-educated, equipped with professional and pedagogical formation, full of human love with ethical concerns, principled, respectful, who knows how to listen to the other person. Service groups such as spiritual therapist, social theologian and religious officer can be contacted from the responsible personnel. Although this is a religious duty for those who will be able to attend this duty, it is evaluated that those who will be provided such services should be treated as a human right. To seek healing and to preserve health is the basic principle in Islamic religion. For this reason, investment has always been encouraged for mankind. As stated in the Qur'an, "if any one saved a life, it would be as if he saved the life of the whole people".

1.INTRODUCTION:

The main factor keeping people and nations alive is the human factor. It is possible to maintain the existence and vitality of man in two ways, material and spiritual. The material one of these is the subject of medicine; the spiritual one is the religion. Those who are in the sick are

entitled to receive treatment services as well as the humanitarian rights and expectations of the same interest and support in matters of moral and spirituality.

The practice of receiving religious and psychological support from patients and relatives started and developed early times in western and some eastern countries, but it is seen today that, especially in our country, applications on this scale have already begun to come to a new age. The first steps taken by the idea of opening spiritual support units in hospitals in 1990 and 2000 in Turkey have brought to the surface the day that many infrastructures are lacking in this field. Especially with the protocol signed by the Ministry of Health and the Presidency of Religious Affairs in 2015, this point became clear.

In fact, within the Islamic cultural heritage, the existence of various medical and spiritual intervention methods which were laid in the early time the Prophet Muhammad (Peace be upon him) and, applied in companions and their followers, and reflected in practice in the Ottoman state time, can not be denied. These are rights and duties that must be fulfilled against the patient and his/her relatives. It is possible to be aware of these issues in Islamic sources, especially in hadith books and in books called "Tıbb-i Nabavî". Scientific researches that have been made nowadays showing that more recently new works have been done this area. There are some books published in our country around the topic, articles, scientific congresses and symposium proceedings.

This study aimed to emphasized the main idea that these subjects have been written in our own resources for a long time and their projections can easily be reached. It is also aimed to contribute to the world of Islamic science, to other researchers, to be the forefront of new researches. Thus, on this basis aims to raise awareness about receiving spiritual support which is a right of humanity in society.

1.1 SPIRITUAL SUPPORT AND IMPORTANCE IN ISLAMIC WORKS

To perform spiritual therapy, giving morale to patients and their relatives, contributing to religious education, chatting with them and answering their questions, meeting religious needs, facilitating prayer and worship, and such similar methods and practices have undoubtedly taken its place from the earliest works of art in Islamic sources; in addition to interview sessions with patients and their relatives that are special field of expertise and practiced in European countries. The delayed steps to overcome the shortcomings identified in the same way for awareness and passion in our country constitute the problem of the fact that some regional implementations still can not be carried out publicly in the strict sense.

Morale worlds of humans can be adversely affected when people suffer from pain, trauma and various physical losses in their illness. This is also true for patients' relatives. It may be that these people are weakened in their religious life and in their connection with the creator, in proportion to the damage suffered. Even those who can not take precautions for themselves are involved in suicide attempts, depending on their belief weakness.

For this reason, named as right to receive spiritual care or spiritual support containing a series of support activities such as strengthening the communication between the person and Allah, pointing to the testimonial mystery of world life, emphasizing the belief in the hereafter, giving religious and moral education services about situations before or during death can be mentioned. The spiritual education which seems to be heavy and tough, but which is beneficial to the

person in hand, gives the person consciousness and peace. It is explained that there are positive situations of things which are thought to be negative. Belief education, moral and consolation are given to the patients.

1.2 HOW TO SUPPORT PATIENTS AND THEIR RELATIVES?

It is aimed to make a general improvement in this area that we find the first examples this service among behaviors of the Prophet Muhammad (Peace be upon him) In essence patient visits, that respond to the consciences of Muslims, popularization of spiritual care and support services in hospitals in official sense will contribute to augmenting a sophisticated consciousness around the issue. It is aimed to be passed on a life. This idea, which is to be made more effective by an official protocol between the Presidency of Religious Affairs and the Ministry of Health.

This opinion, which is to be made more effective by an official protocol between the Presidency of Religious Affairs and the Ministry of Health is aimed to be passed on a life by more professional and specially trained trained specialists, as moving beyond individual practices and efforts.

Supports will be taken from well-trained hospital experts who are experienced, successful; with knowledge of human psychology, religious formation and at the same time are diligent and obliged to provide this service to themselves, and the needs of patients in this issue will be met. Nowadays, it is known that this practice has been tried especially in a few hospitals selected from certain regions in our country and that some new methods and regulations are required to be passed on. It is almost true that if we say no one is caught up in the disease. It was noted that the most severe scourges were given to the prophets, and that later on, people were infected with various diseases and disasters according to their spiritual rank (Buhârî, 1990: Kitâbu'l-merdâ, 3). It has been noted on hadith that the Prophet Muhammad (Peace be upon him) has also suffered extremely severe pain and has had discomfort.

It is also narrated that meed and rewards will multiply if they are patient in such cases (Buhârî, 1990: Kitâbu'l-merdâ, 3). Sometimes, diseases give people some virtues and benefits. Both having a healthy body and to fall into bed by getting sick are the events for people created by Allah. The visit to the patient was also emphasized with emphasis on Islamic thought (Buhârî, 1990: Kitâbu'l-merdâ, 4).

As it is expressed in Qur'an from tongue of prophet Abraham (Peace be upon him) the point which one can not ignore is that "And when I am ill, it is He Who cures me" (Heyet, 2007: Şuarâ 26/80).

There is no doubt that man always wants good health, blessings, and peace from Allah. As well as being unable to become a patient, he or she takes preventive measures by taking regular care of his or her life before becoming ill. Despite this, if she is still ill, this time she will be patient and willing to take it or want to get over it with supplications. In the case of good patience, the end of patience is also emphasized in the hadith as "heaven". (Davutoğlu, 1979: 10/6471). There may be some wisdom that the illness has gained as an unwanted state. If the disease can be countered by good patience for strong believers, it will be a means of cleansing one from sin.

The Prophet Muhammad (Peace be upon him) said in this subject like that "If there is a pain or a grueling, a sickness, a sadness, or even a sorrowful grief upon the believer, some of his sins are covered with him" (Buhârî, 1990: Kitâbu'l-merdâ, 1; Müslim, 1991: Kitâbu'l-bir, 14).

The disease reminds man that he is needy, and he is in need of Allah in every way. He establishes an emotional connection with Allah through disease, it allows him to take refuge in Allah.

A man who is not sick deems his power and might from himself. He behaves as if he does not need anyone else. But when he get sick or understand that a little virüs or microblogging himself into a bed, he knows that he is helpless and needy; yet Allah is the almighty, and he keeps all things under his command. The disease reminds men of death. It teaches that it is necessary to establish a balance between the world and the afterlife. He learns the transience of the last few seconds in the world and that he should not give over much importance to this world. He should know what is given here is to gain the welfare of the Hereafter.

The disease teaches people to consider what happens to the sick person, to empathize with other patients and to be acquainted with them. Man has embraced a lusty, relaxed fondness, and thoughtles life style, mostly when he is in good health. As such, as he does not think of himself, even never thinks about patients. However, when he is sick, he thinks in what extent the patients are in trouble, especially the patients with chronic and terminal illnesses who are in need of care and who are very close to the moment of death. He does not forget these people.

The disease remind man that he should repent from his sins and return the truest path that Allah will be pleased. It is a known fact that an affluent and healthy man sees himself competent, when his worldly affairs are on the road and he has power and strength. He always wants more and it becomes more inclined to self and sins more than everybody. He can fall into prudence and go astray (Heyet, 2007: Alak, 96/6, 7). He Becomes conscious when get sick, realizes that ideal life is not a rambunctious life in its own way, then he repents and make remedy/corrects himself.

The sick person visits relatives and asks them for their state. He will be both in their services and prays to them. On the other hand, anyone who is sick experience the events of prayer, idiosis and dhikrs. The actual relationship and dialogue with the Creator can give him spiritual pleasures. It has been witnessed among people that some patients occasionally during the visits, with this mood enthusiasm and joy they could not help themselves, expressing their wishes by saying “I wish I could have been attained in this exhilarated situation long before” / “I could access my goal”.

It has been gained that physical/anatomical disease and calamities humans face have no considerable value apart from the harms destroying their spiritual life. The disease protects the person from greater harm. So with the illness one understands better: He always thinks of sins before death, must know that hereafter as to be certain, he should see that there is a creator in the universe and should know Allah.

1.3 WHO CAN BE ASSIGNED TO THIS SERVICE? WHO MAKES RELIGIOUS CARE?

It is useful to determine what kinds of topics and methods have been used in the past in terms of support for patients by going down to Islamic sources such as classical and contemporary. The experts who will be trained in this area will of course carry this issue further by adding today’s modern techniques. Otherwise, as it is expressed in the Turkish proverb saying “the half-doctors causes to loose life, half-hodja causes to loose the religion”, if this vital work are not done by the specialist, but by the imitators; then it gives the inverse result, not the desired one.

Applying to the help and treatment of a fake-physician while, a qualified doctor is there, as it could cost a person's life, an uninformed clergyman may inadvertently ignore contemptuous thoughts (Aksoy, 1994: 1/467).

Therefore, the competency of those who serve in the fields of medicine and religion once more prevails and/seen clearly. It is therefore hoped that the material investments to be made by the official institutions, especially in the fields of health and theology, will eventually return to the people and the social life in a positive way.

It is recommended that the personnel to be selected for the application in Turkey should be subject to short-term or in-service training courses (Altaş, 2015: 158). Of course, imams who are responsible for prayer and funeral services should not come to mind only when it comes to the presentation of religious services in hospitals. These services, of course can be fulfilled with a faithful, loyal and devoted imam who is always well-educated, equipped with professional and pedagogical formation, full of human love with ethical concerns, principled, respectful, who knows how to listen to the other person.

In addition, these services could be performed by preachers, muftis, Qur'an course instructor, etc. religious services people and religiously trained specialist religious consultants persons who will serve in hospitals (Altaş, 2015: 167).

2. PATIENT VISIT IN PROPHET'S HADITHS AND SOURCES

In the Qur'an, Eyyub's disease and patientness for years, in the end request for help by prayer and invocation, then he is healed by Allah, and his troubles are resolved, and again his enlightening and attainment to the blessings of Allah are clearly described (Heyet, 2007: Enbiyâ 21/83, 84). The holy hadith also indicates that the patient visit is such an important. On the other hand, Prophet Muhammad (Peace be upon him) himself had visited patients in his own life and reminded his companions that visiting the patients is one of the Muslims' rights to each other (Buhârî, 1990: Kitâbu'l-merdâ, 4). It has also been witnessed that there is a special branch under the name of Tıbb-i Nabavî, as the stories narrated from the Prophet around the subject constitute a very wide amount and there are individual titles (ahkâmu'l marîd) related to the patients in hadith books. Here, it is seen that healing verses and prayers are referred and again the case has been approached by certain asmâu'l-husnâ dhikr and prayer, besides the methods of healing.

As regards the practice of spiritual care during terminal period, this term is also referred to as "spiritual care in the services of death support". Terminal period is the moment of death. The terminal illness, that the on-going patients are suffering from, is described and mentioned on fıqh sources as "maraz-ı mavt (terminal illness)" (Erdoğan, 2005: 344; Seyyar, 2015: 304).

By considering the fact that patients are in need of mercy and compassion more than ever in their deathbed, the patients is faced to one of two possibilities between recovery and death in these periods; therefore and accordingly they are regarded as a definite necessity to be reminded that they are being tested by faith and patience, and that they should be reminded that being connected with Allah and meeting to Allah will be in good shape with worship and remembrance. Because what man has done and earned throughout life finds its value if he gets to Allah with a rightest lifetime and salutation of faith gifted to him in his last moment. Therefore, it should be more conscious at this point as showing the necessary support, interest and closeness to the patients in their terminal period. Service groups such as spiritual therapist, social

theologian and religious officer can be employed from the responsible personnel (Seyyar, 2015: 304).

Although this is a religious duty for those who will be able to attend this task, it is evaluated that those who will be provided such services should be treated as a human right. By not ignoring the fact that the patients may be from different sects and beliefs those who are willing be guided in religious matters, those who wish to worship should have their room prepared and they should also be helped to get a good education by preparing the necessary planning and environment.

Some patients should avoid the misconceptions in their mind that illness and death is the end of life, and they should be thaught that death is a kind of permition and journey in the sense of transition from world to the life of hereafter.

The role of people's anxieties and worries in their recovery or in the further development of their illness is an irrefutable truth. For this reason, they should be encouraged to evaluate their illness times in a good manner. Instead of wishing for death, it should be taught that it is more right to live in hope of healing, and death is not a priority desire.

The patients must be reminded of the necessity of sustaining life without interrupting the connection between them and nourishing the idea that there is a creator in the universe. In this regard, it is important to emphasize the importance of continuity in the life of worship, as well as having a firm belief.

In this innovative work, hospitals will also be required to physically prepare and equip for such services, a support unit for specialists, and meeting and seminar halls in order to raise awareness of masjid and hospital employees. This subject should be well understood by the hospital administrators and then transferred correctly to the staff of the hospital. For this reason, it will be more accurate to hire those who know the patient, the hospital, the person, and accept these matters voluntarily, also knowing the subjects requiring human psychology and religious specialization. It is foreseen that the human resources for this services should be provided by Presidency of Religious Affairs, in coordination with Ministry of Health and Higher Education Institutions.

2.1 SÛRAH AL-FÂTIHA AND SUPPLICATIONS AS HEALING VERSES

It should not be forgotten that He who gives the disease also created the healing. As long as you search the ways of treatments.

We need specialist doctors in medicine as well as sometimes qualified staff who will be consulted religiously in the world we live in. To seek healing and to preserve health is the basic principle in Islamic religion. For this reason, investment has always been encouraged for mankind. As stated in the Qur'an "if any one saved a life, it would be as if he saved the life of the whole people" (Heyet, 2007: Mâide, 5/32). On the other hand, it is accepted as a heavy suicide killing a person unjustly is equivalent to the slaughter of all humanity.

As struggling practices with disease coming from the Prophet Muhammad named as "Tıbb-i Nabavî" are considered to be effective in the name of medicine of Prophets, it is counted also among the general assumptions that some of the verses in the Qur'an will be a source of healing, along with the attributes of Allah and invoking the beautiful names of Allah. These verses are called "healing verses", since the verb and name patterns derived from the root of healing in particular exist. Apart from these verses, there are also some prayer patterns taught to the companions in the hadiths, the treatment of pain was performed by reading them.

It is also noted that by reading the Sûrah al-Fâtiha and massaging the painful area the positive results are obtained. There are various narrations from companions on this issue. In this context, İbn Kayyim el-Cevziyye (death: 751), described and told the event that he personally experienced saying as "Sûrah al-Fâtiha is good for both physical discomforts and spiritual discomforts. I was suffering from severe pain during restraint and at other times to limit my ability to move and as a first hand I immediately read the Sûrah al-Fâtiha, and I saw the soreness immediately cut off after I rubbed the sores on the aching areas. I repeatedly read the Sûrah al-Fâtiha on a glass full of Zamzam and then drank the Zamzam water. I found the strength and benefit I have not found in other drugs."

There is one important point that he especially wants to underline is that: "To have a full faith in a strong belief and to be away from the doubt and to be aware of the fact that Allah is the One who will be called for help" (İbn Kayyim, 1996: 80).

One of the things to be aware of is the issue of what prayer or kind of âyats is best for which discomfort, and then reading those that are appropriate for them. Here, it plays a major role that the patient must keep his belief strong, has to ready for treatment, has to have own desire for healing. It is clear that this is similar to the rule of medicine saying "to give right medicine for the right disease, at right dose".

As it is mentioned at the sources and seen in the practices of the Prophet, making a contact with patient during patient visit, for example, by keeping his hand or putting hand his forehead, one can establish an emotional communication with the patient. In this case, the message giving to the patient that you are near to him and his pain is being felt will be reinforced (Altaş, 2015: 163).

3. CONCLUSION

Like diseases, death is not what people desire and want. At the time of illness, the intention of to be clean from sin, patience, tolerance should be taken as basis.

Complaining, grouching and rebelling of patient are not accepted as rigth behaviors during the illness. It is necessary for the visitor who is beside the patient to pay attention to this point, that is, to praise it with positive/positive thought. It should not be overlooked that he wishes death for any hardship. If he who is patient wants to do something, he should appeal like this, "Oh my Allah! If life is good to me, let me live! No, if it is good for me to die, let me die!" (Buhârî, 1990: Kitâbu'l-merdâ, 19).

Because, it will not benefit him one's desire to die. By asking for life instead of death, the following picture appears: If the person is already a good person, he/she can do more charity; if he is a sinner, he will repent of his sins, abandon his evil course, and ask Allah's intercession and his forgiveness (Buhârî, 1990: Kitâbu'l-merdâ, 19).

There is always a benefit in knowing that death and life are created for people. Because these are made to test and try out who will do better things and behave better as Qur'an says "He Who created death and life, that He may try which of you is best in deed" (Heyet, 2007: Mülk, 67/2). Neither life is not a meaningless existence, nor death is not a destruction that is endlessness in its end. On the contrary, life is a milestone in the field of good activity, and death is a turning point that allows us to pass on to the field of eternal existence where the opposite of these activities will be seen. Death is a stimulus from this point of view.

To summarize the last spiritual tasks we can perform for the patient in the deathbed, it is possible to list the following: The patient on death row should be visited after getting necessary

permissions. During this time good and nice things should be mentioned near the patient. In this issue, the Prophet Muhammad (Peace be upon him) recommends that thing: Say beneficial things, when you are near to a patient or death person. Surely the angels say "Âmen" for that thou hast spoken therein (İbn Mâce, 1994: Kitâbu'l-cenâiz, 4).

Religious advice keeping their souls pleasant should be made for the person on death row and the person next to him, and family members who can perceive and in accordance with their level. For instance, a hadith describing how a person's deeds can continue without interrupting even after his death can be conveyed.

In this context, a hadith saying like this can be read "When a person dies, the deed goes off, but three things are excluded: running charity, beneficial knowledge, and righteous child making beneficial pray for him" (Müslim, 1991: Kitâbu'l-vasiyye, 3).

As a believer can see the angel of death in its best form as a grace of Allah at the moment of death, it is told that he can also see his place in heaven. For this reason, death will not be something that will cause spiritual suffering for the believing spirits. In this case, the believer's face shines, smiles because of his spiritual pleasure, and the tears of joy can flow from his eyes. The believer's souls are taken by the angel of death at a moment when they are so pleasant and comfortable. In the other world there will be beautiful- faced angels who meet him again. The angels say, "Peace be with you!, Peace be on you; enter ye the Garden, because of (the good) which ye did (in the world)." (Heyet, 2007: Nahl, 16/32).

Sûra's from the Qur'an should be read beside the person who is about to give his last breath. The person who reads the verses of the Qur'an will remember Allah and the Prophet and he will be able to acquire a spiritual atmosphere of faith line on that he will deliver his soul more easily. Sûrah al-Yâsîn should be read especially in the sense of suggestion in terms of pointing to the motives of the Hereafter and the truths of faith. It has been reported that the Prophet recommends reading the Sûrah al-Yâsîn near the dying patients (İbn Mâce, 1994: Kitâbu'l-cenâiz, 4).

Patient who is known to be very close to the death must be told "the word of testify (kalima-i shahâdat) and the word of unity (kalima-i tavhîd)". If this is not possible, these words should be repeated frequently beside the person to die. He can be invited to the repentance and forgiveness without compulsion. Because, it is pointed out in the hadith's that a faitful person whose last word is to be "there is no god but Allah" - word of unity- he will enter the paradise. (Müslim, 1991: Kitâbu'l-cenâiz, 1, 3; İbn Mâce, 1994: Kitâbu'l-cenâiz, 3; Seyyar, 2015: 305).

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THE EFFECT OF SOCIAL SUPPORT ON THE LIFE QUALITY OF THE PATIENTS HOSPITALIZED IN THE MERAM MEDICAL FACULTY OF THE NECMETTIN ERBAKAN UNIVERSITY

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ABSTRACT

Aim: This study has been made in order to detect the relation between the social support and quality of life that the patients perceive.

Importance: It is thought that knowing how and in which areas cancer and its treatment effects the patient and his family's life quality will be helpful to the cancerous patient and his family to increase their life qualities. Therefore, identifying life quality and perceived social support level of the patients placed in the sample of the study and taking necessary precautions are important in terms of contributing to the treatment process and creating a remedy.

Method: Questionnaire has been used in collecting data (socio-demographic questions and questions relating to the illness), Ferrans and Povvers 'Cancer adaptation of the quality of life index - 111(EORTC QLQ-C30)' has been used for evaluating the quality of life; and '*Multidimensional Scale of Perceived Social Support* (MSPSS) has been used in order to identify the social support that the patients perceived.The cancerous patients hospitalized in the clinic of oncology of the Medical Faculty of Meram situated in Konya in 2015 and the patients who came to the chemotherapy unit in order to get outpatient treatment has created the universe of the study.110 patients who are suitable for the research criteria and who accepted to participate in the research, have composed the sample of the study.

Results and Findings: As a result of study, a significant positive correlation has been found between the social support that the patients perceived and their total quality of life.When the average scores that the patients in the study group took from the life quality scale are evaluated, it has been determined that the highest average score belongs to psychological / religious subscale 24,27±5,79 and the least average score belongs to health and mobility subscale 21.25±5.82.When the average scores that the patients took from the social support scale are evaluated, it has been seen that the highest average score belongs to the subscale perceived from family 25.21±4.72, and the least average score belongs to the subscale perceived from a special person 15.92±8.82.

1. INTRODUCTION

Following the World Health Organisation's (WHO) defining the health not only as not having illness and disability but also physical and mental social well-being, the issue of quality of life has started to gain importance in health care applications. With the acceptance of the illnesses had not only physical dimension but also psychosocial aspects,the importance of the concept of the quality of life has increased (Fries, Singh,1996).

As the importance of the quality of life related to health increased, various definitions related to the concept have been developed. In the study of (Rustoen et al., 1999), the quality of life was defined as "person's sense of well-being that derived from being pleased or not pleased about the vital events important for the person (Rustoen et al., 1999). Akyol (1993) defined the concept of the quality of life as intersection between satisfaction of individuals and social relationships (Akyol, 1993). De Haes and Knıppenberg (1986) defined the quality of life as" a vague and sensitive thing that everybody talks about it but nobody knows what to do clearly" (De Haes and Knıppenberg, 1986).

These definitions made in the literature come along with a content covering all aspects of life like health area, socio-economic area, psychological area and family area. It's thought that it effects all these life areas in cancerous patients (Rustoen et al.,1999). Traditionally, cancer diagnosis are consubstantiate with connotations that gives rise to thought of pain and death in the patients. Therefore;cancer is a period of experiencing distressed ,fearful and emotional collapse in the people's life (Courtens et al.,1996).As a result of the increase in the life spans of cancerous patients and development of new treatment methods,the thought that the cancer is a chronic disease has been increasingly accepted by the patients (Schag et al 1991; Courtens et all 1996).While fighting a chronic disease,the social support they will receive from surroundings will be helpful to the treatment period.

In this context, the relation between the social support that the cancerous patients perceive and the quality of life of them has been tried to be identified on the cancerous patients being treated in the Medical Faculty of Meram in our study.

2. MATERIAL AND METHOD

The study has been made on the patients hospitalized in the clinic of oncology of the Meram Medical Faculty of the Necmettin Erbakan University between the dates of 01.04.2015 and 07.04.2015 and on the patients who came to the chemotherapy unit in order to get outpatient treatment.

The data was collected from the 110 volunteer patients by the researcher using face to face interview technique. A research took an average of 15-20 minutes. The data was collected through three forms. Questionnaire has been used in collecting data (socio-demographic questions and questions relating to the illness), Ferrans and Povvers 'Cancer adaptation of the quality of life index -111(EORTC QLQ-C30)' has been used for evaluating the quality of life; and, '*Multidimensional Scale of Perceived Social Support* (MSPSS) has been used in order to identify perceived social support. The data obtained was evaluated through the ready statistical program SPSS 16. In the detection of the significance of average rates, the t test and the anova test was used in the study, the reliability of the study was found positive. In this study, reliability analysis results of the scale has been found between 0,73 -87. By Eker and et al, Cronbach Alfa internal consistency coefficient was calculated separately for subscales and found between 0.80 and 0.92 (Eker, Arkar, Yıldız, 2001).

Implementation of the Research only in the Meram Medical Faculty of the the Necmettin Erbakan University and not

being able to be understood some of the questions in the scale by the patients composed the limitations of the study. All the cancerous patients cannot be generalized by this study.

3. FINDINGS

66.4% of the 110 patients joined the research is consisted of women. 37.6% of the patients are at the age group of 50-59 and they consist of the majority of the sample. 51.8% of the patients are primary school graduate and 85.5% of them are married. In the job group, the housewives has consisted of a large part with the porsion of 53.6%. 92.7% of our patients have social security.While 84.5% of our patients are living with their spouse and children,10% don't have child. 28.2% of them have three children. In terms of residence places, 63.6% of them are staying at the city center while 9.1% of them are living in the country like village or town. 84.5% of them have house at the place they stay. In terms of annual income, the portion of 72.7% is between 0 -15,000 TL and this shows that the patients in the overall sample have lower level of income. 41.8% of our patients have been diagnosed in the last 6 months and 78.2% of them have been getting chemotherapy treatment.While 73.6% of our patients don't have additional diseases, 26.4% of them have additional diseases. 69% of the additional diseases found in the patients is hypertension and 31% is diabetes.

The average rates of the quality of life of the patients which is intended for their identifier features obtained by surveys and related test statistics are presented in the Table 1. According to this, when the quality of life of the patients as regards of their gender is analysed, the men's average rate of the health and mobility subgroup scores and the psychological/religious subgroups scores are high and this is not significiant statistically. However; while there was a statistically significiant relation with the female patients in the social and economic subgroups, the difference in the family subscore couldn't be find significiant. When the total quality of life scores are analysed, we see that there is not a relation between gender factor and quality of life.It was pointed out that there was not a relation between gender factor and quality of life scores of the patients in the study of Kızılcı in1997 which is named the factors affecting cancer patients getting chemotherapy and their relatives,made in the Research and Application Hospital of the Medical Faculty of the 19 May University (Kızılcı,1997).

When the quality of life of the patients according to their age groups are analysed, the highest average score of the health and mobility subgroup and the family subgroup is at the age group of 50-59 and the difference has been found significiant. The highest average score of psychological / religious subgroup belongs to the age group of 60-69 and the difference between them has been found significiant. The highest average score of the social and economy subgroup and total quality of life score belongs to the patients at the age group of 40-49 and the difference between them has been found significiant. In the literature, Kızılcı and Reis has reached some findings which shows that the quality of life increases with the increase of age (Kızılcı,1997; Reis,2003).

When the quality of life of the patients analysed according to their educational status, the highest average score of the health and mobility subgroup belongs to the secondary school graduates and the difference hasn't been found significiant. The highest average score of psychological / religious subgroup belongs to the primary school graduates and the difference between them hasn't been found significiant. The highest average score of family subgroups belongs to the university degree graduates and the difference has been found significiant. The highest average score of the social and economy subgroup and total quality of life score belongs to the university degree graduates

and difference has not been found significiant statistically. In the studies Arslan and Kızılcı made over the cancerous patients, total score of quality of life has been found high in the university degree graduates according to Rolls Royce quality of life scale (Arslan, 2003; Kızılcı, 1999).

When the houses' being property or rent is analysed, the highest average score of the total quality of life and in its all subgroups belongs to home owners and the difference has been found significiant statistically.

According to annual income, the highest average score of psychological / religious subgroup has been found in the patients who has income between 30,001 TL and 45,000 TL and the difference has not been found significiant. The highest average score of the total quality of life and in its all other subgroups belongs to the patients who has income over 45,000 TL and the difference has been found significiant. In the study that Kızılcı made on the cancerous patients, quality of life was found higher in the patients who had not experienced financial difficulties (Kızılcı, 1997). Also in the study that Bergner had made in 1989 shows that financial sufficiency increases the quality of life (Bergner,1989). In the study that Reis made on the cancerous patients, the quality of life was found higher in the patients with good income and the difference has not been found significiant statistically (Reis, 2003). There is parallelism between these examples in the literature and our study.

In the relation between the quality of life and whether the patients get chemotherapy or not during the treatment process and in the health and mobility, social and economy and in the family subgroups, the highest score belongs to the answer yes and the difference between them has not been found significiant. In the average score of psychological / religious subgroup and the average score of the total quality of life, the highest score comes to the answer yes, too and the difference between them has been found significiant.

To the question of additional diseases out of cancer, in the health and mobility, social and economy subgroups and in total quality of life the highest average score belongs to the answer no and there couldn't be found a significiant relation between them. The highest score in the family subgroups was given to the answer no and the difference has been found significiant. The highest average score of psychological / religious subgroup has been found in the answer yes. The difference has not been found significiant statistically.

When the average scores that the patients got from the quality of life scale were analysed, it has been determined that the highest score belongs to the family subscale and the lowest score belongs to health and mobility subscale.

When the perceived total average social support scores were analysed, the average score of social support from family has been found as 25.21 and the average score of social support from friends has been found as 18.05 and the average score of social support from a special person has been found as 15.92. The total average social support score has been found as 55.92.In this case, the highest perceived total average social support score derives from family and the lowest perceived total average social support score derives from a special person. We can think that the patients get more social support from family members like spouse, child, mother, father, sibling or relatives. In a study Scmith E and et al. made in 1985, the most important source of support for married women is their husbands in the period of 1 to 3 months after genital cancer diagnosis (Scmith et al., 1995). In an other study made by Tuna in 1993,the patients expressed that they got support from their spouses at the first place and they got support from their children at the second place. There is parallelism between these studies in the literature and our study.

In the total quality of life and in its all subgroups average scores, patients' not having social security has come out the most. The difference between them has been found significiant statistically. In this case, we can think, it is effective that 66.4% of the patients' being women in terms of gender and 53.6% of theirs being housewife when analsyed in terms of job. In the study Kızılcı made on cancerous patients, it was stated that quality of life total score was higher in those who does not have social security (Kızılcı, 1999).The results of our studies is parallel with the Study of Kızılcı. There couldn't be obtained a significiant result between the quality of life of the patients according to their profession groups and their subgroups. In the studies of Yıldız, Karamanoğlu and Reis which takes part in the literature, there couldn't be obtained a significiant result between profession groups and the quality of life, neither (Yıldız,1998; Karamanoğlu,1999; Reis,2003).

4.RESULT AND RECOMMENDATIONS

In our study on the effects of social support on the quality of life in the cancerous patients in the Medical Faculty of Meram situated in Konya province, it is understood that there is not a direct effect on the quality of life of gender, educational status, job, social security and whether the patient have an additional disease or not and also it is understood that there is relation between the quality of life and marital status, residence status, income status and getting chemotherapy. Some differences were observed when researches were observed in terms of subgroups. Health and mobility subgroup average score was found high in the never married patients; however, there couldn't be find a significiant relation between them. There couldn't be find a significiant result in psychological / religious and family subgroup's annual income. There is not an effect of income status on the quality of life of the patients in these two groups. The effect of patients'getting chemotherapy in the treatment period over their quality of life has been found significiant; however, it is thought that there is not a positive effect of giving chemotherapy in the social and economy, psychological/religious subgroups and family subgroups. There was reached the outcome that there was not an effect on the quality of life whether there is additional diseases out of cancer or not but it was vice versa in the family subgroup.

The quality of life scale total average score is 22.27±5.24, reliability analysis results of the scale has been found as 0.91. The total average score the patients got from the quality of life scale has been found as 4 at least and 30 at most. 0 point shows the lowest quality of life and 30 points shows the highest quality of life in the quality of life scale. We can say that the patients have taken scores above the average; in other words, the quality of life of the patients are good. Social support total average score has been found as 25.21±4.72 and Cronbach alpha rate has been found as 0.71.

There could be obtained significiant positive results in the correlation test carried out between the multidimensionally perceived social support scale and quality of life. When the relation between the average scores of the patients' quality of life perceived from their family and total quality of life and all subscales of quality of life, there has been found a positive relation between the social support perceived from the family and all scales of the quality of life.

The perceived social support's being the most from the family has proved the family reality. There can be provided educational programmes and financial regulations for the relatives of the patient by the government. Because the social support score from a special person (from nurse) has been found low in our study, there can be held programs, seminars and etc. for the

medical staff aiming to increase the quality of life.

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Identifier features	Number	Health and mobility subgroup score X±SD	Test ve p Rate	Social and Economy subgroup score X±SD	Test and p Rate	Psychological/ religious subgroup score X±SD	Test and p Rate	Family subgroup score X±SD	Test and p Rate	Total Quality of Life X±SD	Test and p Rate
Gender											
Male	37	21.26±6.21	t =-0.08	21.39±5.57	t =0.711	23.81±6.14	t =0.584	21.88±7.24	t =1.615	21.85±5.69	t =0.559
Female	73	21.25±5.66	p=0.994	22.20±5.65	p=0.479	24.50±5.64	p=0.560	23.98±6.02	p=0.109	22.48±5.03	p=0.552
Age Group											
24-39	7	18.54±7.92	F =5.392	20.50±7.82	F =3.977	21.58±7.92	F =3.32	21.52±7.97	F=10.504	20.02±7.56	F =6.604
40-49	28	22.62±4.49	p= 0.001	23.22±4.66	p=0.005	25.31±4.41	p=0.013	23.98±5.16	p=0.000	23.59±3.81	p=0.000
50-59	37	22.33±4.59		22.36±4.55		24.34±5.46		25.32±3.53		23.16±3.86	
60-69	25	22.01±4.91		22.97±4.99		26.04±3.08		23.63±6.18		23.22±4.08	
70+	13	15.24±8.21		16.69±7.56		19.86±9.34		14.23±8.28		16.28±7.75	
Educational Status											
Illiterate	24	19.15±8.18	F=1.408	16.60±8.01	F=1.991	22.51±8.13	F=2.078	19.93±8.82	F=3.483	19.30±2.89	F=2.001
Primary	57	21.90±5.13	P=0.245	22.39±4.78	P=0.120	25.48±4.14	p =0.108	25.98±5.65	P=0.018	21.14±2.40	P=0.118
Secondary	18	22.05±3.14		22.45±2.68		23.96±2.81		23.55±5.35		20.32±3.22	
University D.	11	21.17±6.09		23.75±6.07		22.28±9.16		26.51±3.49		24.23±1.97	
Marital Status											
Married	94	21.63±5.47	F= 2.368	22.48±5.10	F= 6.268	24.97±5.31	F= 6.631	24.05±5.96	F= 4.880	22.81±4.73	F =4.879
Never married	5	22.05±4.85	p=0.099	23.42±5.06	p =0.003	23.53±4.47	p=0.002	18.22±6.38	p=0.009	22.07±4.39	p=0.009
Widow/widower	11	17.68±8.15		16.53±7.39		18.59±7.43		19.00±8.66		17.76±7.6	

Table 1: The Average Distribution Scores Of The Quality Of Life According To The Patients' Identifier Features

Identifier features	Number	Health and mobility subgroup score X±SD	Test ve p Rate	Social and Economy subgroup score X±SD	Test and p Rate	Psychological/ religious subgroup score X±SD	Test and p Rate	Family subgroup score X±SD	Test and p Rate	Total Quality of Life X±SD	Test and p Rate
Residence Status											
Home Owner	93	21.95±5.43	t =3.046	22.61±5.06	t =3.074	24.75±5.34	t =2.067	23.87±5.96	t =2.272	22.99±4.70	t =3.095
Rent	17	17.43±6.57	p =0.003	18.22±7.08	p =0.003	21.63±7.47	p =0.041	20.04±8.40	p =0.025	18.78±6.68	p =0.003
Income Status											
0-15,000	80	20.35±5.80	F =4.368	21.24±5.75	F=4.492	23.81±5.51	F =2.075	22.39±6.91	F=2.407	21.50±5.32	F=4.365
15,001-30,000	24	22.47±5.18	p =0.006	22.36±4.37	p =0.007	24.41±6.76	p =0.108	24.90± 4.73	p =0.071	23.16±4.30	p =0.006
30,001-45,000	3	27.27±2.11		29.00±1.14		29.66±0.57		29.10±0.79		28.40±1.16	
45,001-Over	3	29.39±1.05		29.68±0.54		30.00±0.00		28.00±3.46		29.36±0.55	
Are you getting chemotherapy?											
Yes	86	21.83±5.43	t =0.095	22.43±5.27	t =0.246	24.74±4.88	t =0.009	23.78±6.07	t =0.131	22.80±4.78	t =0.038
No	24	19.17±6.79	p =0.047	20.14±6.50	p =0.078	22.56±8.20	p =0.103	21.48±7.73	p =0.127	20.37±6.38	p=0.045
Do you have additional diseases?											
Yes	29	20.09±6.54	t =-1.257	20.96±5.63	t =-1.084	24.32±4.68	t =0.055	20.94±7.49	t =-2.294	21.20±5.52	t =-1.283
No	81	21.67±5.53	p=0.211	22.28±5.60	p=0.281	24.25±6.17	p=0.956	24.11±5.93	p=0.024	22.65±5.12	p=0.202

Table 1: The Average Distribution Scores Of The Quality Of Life According To The Patients' Identifier Features

Identifier features	Numb er	Health and mobility subgroup score X±SD	Test ve p Rate	Social and Economy subgroup score X±SD	Test and p Rate	Psychological/ religious subgroup score X±SD	Test and p Rate	Family subgroup score X±SD	Test and p Rate	Total Quality of Life X±SD	Test and p Rate
Social Security											
Yes	102	21.07±5.81	t=-.953	21.64±5.55	t=-1.91	24.13±5.92	t=-0.886	23.10±6.65	t=-1.00	22.08±5.28	t=-1.313
No	8	23.14±5.98	P=.343	25.55±5.37	P=0.058	26.02±3.58	P=0.378	25.5±03.55	P=0.318	24.60±4.27	P=0.192
Job											
Worker	9	22.06±3.37	F=0.522	22.70±4.83	F=0.447	24.51±2.55	F=0.781	24.95±3.64	F=1.142	23.07±2.64	F=0.711
Housewife	59	21.72±5.81	P=0.759	22.34±5.68	P=0.814	22.83±5.12	P=0.565	23.98±6.15	P=0.343	22.83±5.12	P=0.616
Officer	7	21.04±5.78		22.89±6.47		22.62±5.31		24.78±5.67		22.62±5.31	
Retired	30	19.96±6.78		20.64±5.94		20.76±6.20		21.00±7.71		20.76±6.20	
Private Sector	3	23.73±1.08		22.43±2.56		23.16±4.54		24.80±1.0022		23.47±0.84	
Own work	2	20.07±4.04		21.59±4.11		24.95±7.12		1.45±12.09		21.53±5.83	

Table 1: The Average Distribution Scores Of The Quality Of Life According To The Patients' Identifier Features