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Editor-in-Chief

Prof.Dr.Ayşegül YILDIRIM KAPTANOĞLU

Beykent University/School of Health Sciences/aysegulyildirimkaptanoglu@gmail.com

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BULIMIA NERVOSA – A REVIEW

Lambrini Kourkouta[1], Ekaterina Frantzana [2], Christos Iliadis [3], Christos Kleisiaris [4], Ioanna Papathanasiou [5]

Abstract

Introduction: The term bulimia nervosa describes a food intake disorder which is characterized by episodic binge eating (eating very large amounts of food in a short period of time), followed by the effort of purging all the unnecessary calories usually through vomiting, laxatives, diuretics and excessive exercise. **Purpose:** The purpose of this review is to present all aspects related to bulimia nervosa and its treatment. **Methodology:** The material of the study has been recent articles concerning the subject. They have been mainly found via electronic database Medline and the Hellenic academic libraries Link (HEAL-Link). **Results:** Bulimia nervosa is mainly manifested in women in approximately 90% compared to men. It usually starts during adolescence or early adulthood. About 4% of adolescent women suffer from bulimia nervosa. Approximately 50% of people who had suffered from anorexia nervosa develop bulimia or bulimic behaviors. It is difficult to define the total number of individuals affected at older ages for bulimic people are usually secretive. Aside from this, this disorder is rare in children.

Conclusions: Early diagnosis and treatment of bulimia increases the rate of successful recuperation. In cases of severe weight loss, hospitalization with a special diet is needed so as to address the medical and nutritional needs of the patient.

Keywords:
Bulimia Nervosa, Causes, Types, Clinical Signs, Treatment.

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[1] Professor of Nursing Department, Alexander Technological Educational Institute of Thessaloniki, Greece
[2] RN, General Hospital of Thessaloniki "Papanikolaou", Greece
[3] RN, Private Diagnostic Health Center of Thessaloniki, Greece
[4] Assistant Professor Nursing Department of Nursing – Technological Educational Institute of Crete, Greece
[5] Assistant Professor Nursing Department Technological Educational Institute of Thessaly, Larissa, Greece

Introduction

To a significant degree, the bulimic disorder is considered to be unrecognized. The incidence of the disease is estimated to be 1-3% between adolescent and young women. Although not being classified in bulimia types, the tendency for periodic combination of overeating and using laxatives is quite common. Men with bulimia are just about 10-15% while this disorder seems to be more common in homosexual groups of male population. (Peroutsi & Gonidakis, 2011)

The number of people with bulimia nervosa (NB) seeking for help to control their weight is important. Bulimia nervosa related to commercial weight loss programs is touching 30-50%, while patients who have been operated to treat obesity reach an incidence that touches 25-70% in certain groups of the population. (Varsou, 2004)

Generally, the incidence of bulimia has shown a significant increase after the end of World War II. This can be interpreted as the primary result of the changes that have occurred regarding the socio-cultural expectations for women. Especially, the bulimia disorder is prevalent in the Western world and occurs more in developed countries. (Chakraborty & Basu, 2010)
The hypothesis that environmental factors play an important role in the inauguration and presentation of bulimia extracts the fact that immigrants from underdeveloped countries are at greater risk of developing the disorder despite their genetically relatives remaining in their country of origin. Most studies indicate that bulimia is more common in middle and upper socioeconomic strata of society. (Cooper & Fairburn, 2009)

Purpose

The purpose of this review is to present all items associated with bulimia nervosa and its treatment.

Reviewing Method and Material

Recent articles on the subject have been mainly found in Medline electronic database and the Hellenic academic libraries Link (HEAL-Link). They have been the material of the study, with the following keywords: bulimia nervosa, causes, types, clinical picture and treatment. The language of the articles was the Criterion for exclusion of articles except for Greek and English.

Defining Bulimia Nervosa

Bulimia nervosa is a type of eating disorders being specified according to diagnostic and statistical criteria of mental disorders (DSM-IV). The word bulimia (ravenous hunger) is derived from the word ‘vous’ (bos) and ‘limos’ (starvation) while it defines intense binge eating. Bulimia nervosa is characterized by frequent episodes of overeating due to the existence of oppressive feelings accompanied by corrective behaviour aimed at preventing weight gain. (Varsou, 2000) Excessive exercise, purging (self-induced vomiting) immediately after meals, overuse of diuretics and laxatives, and the use of medication that suppresses the appetite or increase the metabolic function of the body belong to behavioural types that bulimic people adopt. According to diagnostic criteria, bulimia is diagnosed when episodes of over-consumption of food occur, at least, twice a week for 3 months. (Zambelas, 2007)
Overeating is defined as the excessive food intake in a certain period of time, at least, in an hour while its quantity is quite larger than the food quantity that the majority of individuals would eat hourly. During this length of time, people completely lose control of food consumption. (Andersen &Ryan, 2010) The difference between a bulimic episode and an overconsumption one is that in the first category, the person consumes small amounts of food but he has no perception of the intake. However, in the second category the quantity of food consumed is greater without loss of food perception from the person. (Abraham &Lewelly, 1997)

Bulimia nervosa has been completely differentiated from excessive food intake; this is due to the fact that the overconsumption episodes are accompanied by specific behavior types, while this tendency is absent during excessive food intake process. (Usu, 1995)

Bulimia Nervosa Classification

There are two types of bulimia nervosa (Meule, Rezori & Blechert, 2014):

- **Purging type:** The individual succumbs in behaviors of medicine abuse such as laxatives, diuretics or he does enemas, and finally, he engages in self-induced vomiting during bulimia nervosa episodes. (Cooper & Fairburn, 2009)
- **Non-Purging type:** The individual adopts other compensatory behaviour such as fasting, excessive physical exercise during bulimia nervosa episodes but he does not use laxatives or engages in self-induced vomiting. (Vasou, 2000)

It is estimated that 66, 6% of bulimia nervosa patients belong in the first type of the disorder. The pathophysiology of that type presents greater severity than that of non-purging type. Obviously, there are most frequent episodes of food overconsumption, longer depression periods and other mental illnesses such as panic disorder. Bulimia nervosa sufferers try overcoming remorse deriving from the food overconsumption. As a consequence, they acquire purging behaviour. Nevertheless, the use of laxatives is an ineffective way of avoiding calorie intake. Self-induced vomiting leads to 50% loss of the quantity consumed, while diuretics or laxatives delay their action around 95%. (Kenyon, Samarawickrema, DeJong, Eynde, Startup, Lavender ... & Schmidt U, 2012)

Bulimia Nervosa Clinical Presentation

The most possible scenario of bulimia nervosa advent is the concern for the person's body weight and the search of help in order for him to lose weight. The symptoms may include abdominal inflation, constipation and menstrual disorders. Individuals suffering from bulimia nervosa rarely present heart arrhythmia as a result of electrolyte disorders. Bulimia is also characterized by inappropriate and continuous tendency of individual for thinner body and body dysmorphic disorder. (Vitousek & Manke, 1994)

A careful examination of bulimic people's diet often reveals their effort to monitor their body weight; they follow a diet and refrain from food of high caloric content until the inauguration of bulimic episodes. Those people often present pathological prejudice about food and diet. They may repeat circles of strict diet or fasting that can be alternated with gluttonous behaviour. Bulimic people usually preplan their episodes of food overconsumption. The food is selected with the criteria of easy ingestion, being removed via self-induced vomiting or being ruminated while it tends to be of high caloric value. (Cassin & Ranson, 2005)

Bulimic individuals avoid events in which the control of food intake can be lost such as parties or dinner in restaurants. The level of their physical activity alternates just like bulimic episodes, and while most bulimic individuals engage in self-induced vomiting right afterwards their meals, there is a minority of bulimic individuals that opt for chewing their food and afterwards they ruminate it without swallowing it. Vomiting is usually achieved with the intentional trigger of Pharyngeal (gag) reflex using the person's fingers or with the use of emetics. (Kaye, 2008)

The common gastrointestinal symptoms that bulimic individuals experience, include abdominal pains which are mainly obvious to the individuals that induce vomiting, abdominal swelling and constipation. Pneumonia can be triggered via the suction of vomiting in the lungs and shock is seldom observed. It is observed that 5% of bulimic women suffer from amenorrhea and a great number of female patients suffer from menstrual irregularity. (Vitousek & Manke, 1994, Kaye, 2008)

Etymology of Bulimia Nervosa

There are plenty of factors but the most important causative factors that accelerate the beginning of bulimic circles include anxiety, sentimental pressure, and lack of interests, hints about food by the family, alcohol consumption, substance abuse and physical exhaustion. The sense of hunger is a relatively uncommon factor that may trigger bulimic episodes. Several factors have been identified they play important role in pathogenesis of bulimia. (Rikani, Choudhry, Choudhry, Ikram, Asghar, Kajal ... & Mobassarah, 2013) These are:

- **Psychological factors:** The individual's difficulties with his self-esteem and with the effective self-adjustment of his personality are enlisted in those factors. (Holland, Bodell & Keel, 2013)
- **Socio-political factors:** They consist of the excessive physical function and stress for the body idol. Also, intense prejudice for slimming is a common trait of both bulimia and anorexia nervosa.
- **Other disorders:** There seems to be a possible relation between other disorders and eating disorders. Acute depression is the most common disorder related with appearance of bulimia. Furthermore, Manic Depressive Disorder (Manic Depression) is more common to bulimic patients related to the rest of the population. Concern, anxiety and other relative Neuroses and phobias are related to bulimia. (Rikani, Choudhry, Choudhry, Ikram, Asghar, Kajal ... & Mobassarah, 2013)
- **Gastrointestinal and Central Nervous System (CNS) Interactions**: It seems there is a complicated dysfunctional interaction between the appetizing factors such as Neuropeptide Y (NPY) and anorexic factors such as Cholecystokinin (CCK) and beta-Endorphin. Bulimics have normal NPY levels which increase after successful treatment. Moreover, bulimic individuals have decreased beta-Endorphin levels, normal Dynorphin levels and low levels of CCK. Studies have shown that the decreased function of C.N.S. Serotonin can play a role in bulimic development. (McCance & Huether, 2018)

Bulimia Nervosa Treatment

The strategies for Bulimia nervosa treatment include eating suggestions and diet reclamation, psychosocial interventions (behavior treatment, interpersonal, psychodynamic and psychoanalytic approaches) in individual, team or familial level, as well as medication. (Mehler, 2011)

- *Nutritional rehabilitation*

The major objectives for the treatment of bulimia nervosa are the reduction of both excessive eating and purgative behavior. The majority of bulimic patients have normal body weight. As a result, they do not aim at gaining weight. Nevertheless, in the case of patients with bulimia nervosa who diverge statistically from normal body weight, they must gain some weight in order to achieve body and sentimental stability. It is essential these patients establish regulated diet that pays attention to calorie intake and all food groups. (Mehler, Krantz & Sachs, 2015)

Even if most bulimic female patients report menstrual disorders, there seems to be no proof of improvement through nutritional re-establishment. Eating suggestions can be used amongst patients with normal weight so as the patients to reduce disturbed eating behaviors. As a result, they would improve their nutritional deficiency, increase food variety and they would be encouraged to adopt healthy eating standards. (Mehler, 2011)

- *Psychological therapy*

The objectives of psychosocial interventions vary and they can include some reduction or restriction the excessive eating and purgative behavior, improvement of attitude of life that relates to the eating disorder, increase of food intake, adoption of healthy exercise patterns, treatment of pathological

situations and clinical characteristics that are expressed in bulimia nervosa. (Wilson, Wilfley, Agras & Bryson, 2010)

- *Individual psychotherapy*

Cognitive behavior treatment is advisable for the patients that express the symptoms of the illness and the underlying situations that concern the disorder. This treatment is a type of psychosocial intervention whose beneficial results have been proved by loads of researchers. The patients who were treated with cognitive behavior treatment showed important reduction in excessive food intake, the frequency of self-induced vomiting and the use of laxatives. Nevertheless, a number of patients that achieved complete abstention from excessive food intake and purging behavior represents a minority of individuals. (Murphy, Straebler, Cooper & Fairburn, 2010)

Practically, there are a lot of other types of individual psychotherapy being used for the treatment of bulimia nervosa such as are the interpersonal and psychoanalytical approaches. The clinical experience also proposes that these approaches help in the treatment of pathological concern of personal problems and traumatic or abusive disorders of bulimia nervosa. (Vasou, 2000)

There is a type of treatment for cognitive behavior that uses techniques where the patients become spectators of bulimic behavior. In other words, they watch a person who consumes excessive food intake then, he induce vomiting in order to remove the consumed food. Nevertheless, the positive effect of this method has not been ascertained yet. (Holland, Bodell & Keel, 2013)

- *Team psychotherapy*

The approach of common psychotherapy is also used for the treatment of bulimia nervosa. The analysis that was exported from a study of 40 teams from bulimic patients proved a mediocre effectiveness of this method. However, the studies carried out one year afterwards reported the maintenance of these positive effects. Also, it has been found that the curriculum of common psychotherapy that combines eating education is more beneficial for the patients for the faster the intervention is, the better results are exported. A lot of clinical scientists prefer a combination of individual and common psychotherapy. (Wilson, Wilfley, Agras & Bryson 2010)

- *Family therapy*

Family therapy has been found to contribute in the treatment of bulimia nervosa in a number of cases. This treatment is applied mainly to adolescents who live with their parents, in adults with domestic/family frictions or to patients being separated couples. The interventions that will help bulimic mothers as well as their children are evaluated. (Le Grange, Lock, Loeb & Nicholls, 2010)

Conclusions

Bulimia nervosa is one from the most basic disorders of food intake and its etiology is multifaceted. Using the term « multifaceted », it is meant that it is possible the disorder to be caused due to biological, psychological or social - environmental factors, which to a large extent, contribute to the adoption of pathological models regarding food intake.

Bulimia nervosa is usually treated outside the hospital. Nevertheless, the patient may need hospital treatment if the disorder is severe or the patients shows serious complications. Early detection and treatment of bulimia increases the rate of successful rehabilitation. In cases of serious weight loss, the patient needs post-hospital follow-up visits with a special program of diet in order the medical and nutritious needs of the patient to be covered. (Grilo & Mitchell, 2011)

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WHICH HEALTH? : A CONTENT ANALYSIS EVALUATION ON THE SYRIA AND YEMEN CIVIL WARS

İzzet ERDEM[1]

Abstract

Civil war is at the forefront of non-human atrocities that have destroyed societies and individuals in both physcially and spritually. Particularly in Syria, one of the parties that have exposed the people to violence and massacre makes the issue of the government of the country an even more graver and tragic. Assad Regime is used for all types of heavy weapons as well as chemical attacks against civilians. Organ losses, injuries and irreparable physical damage have begun to appear to be almost normal in areas of war. In Yemen, starvation, thirst, absence of medical supplies caused epidemics such as cholera.

The method of study consists of a qualitative research method of document review. TRT's news site www.trthaber.com between September 1, 2017 and December 31, 2017 subject to content analysis on Syria and Yemen. The meaning of health in the domestic warfare is critically questioned. The relationship between war and health is tried to be put forward

Keywords:

Civil war, Syria, Yemen, Health, Massacre

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[1] Aksaray University, Faculty of Health Sciences, Aksaray, Turkey.

Introduction

War has become a comprehensive and dynamic concept, which has been exist with the humanity, has changed throughout the history and has been different in terms of method and practice. (Eker, 2015) The wars cause many destruction that cannot be compensated. The impact of this destruction is more evident in children who need adults for their needs. Injuries and deaths as a result of conflicts can be defined as the direct impact of the war. This effect is felt more intensely near the war zone. Other problems arise for civilians who may move away from the war zone. (Oğuz et al., 2016) Children are most affected ones by the results of armed conflicts. The environment of war and violence affects even unborn children (Çelik & Özpınar, 2017).

Purpose

The massacre in Syria and Yemen is a critical question of what sociological health means for the people in brutality and cruelty.

Reviewing Method and Material

The method of study consists of a qualitative research method of document review. A document review refers to an analysis of sources containing information about the subject being searched (Yıldırım & Şimşek, 2008). Document analysis has been preferred because it provides enough information and time saving about the research topic. Thus, TRT's news site www.trthaber.com between September 1, 2017 and December 31, 2017 subject to content analysis on Syria and Yemen. The reason why the news is examined for four consecutive months is that it is a process of war, which is the subject of investigationIn this way the process is considered to be better understood.

In total, 122 new documents which were published in the last 4 months of 2017, were subjected to categorised analyze. The categorised analyze means the division of a message into units and to classify these units due to certain criteria. (Bilgin, 2014)

The Situation Syria and Yemen

In the Middle East in December 2010, popular uprisings in Tunisia began to be known as the Arab Spring. While the governments in Tunisia, Egypt, Libya and Yemen changed, armed non-state actors in the Middle East brought regional instability and chaos (Semin, 2015: 1). Syria is another country where this uncertainty continued since 2011. In Yemen, the severity of violence and war has increased gradually with Ali Abdullah Salih leaving the seat.

The efforts of international organizations, especially the United Nations, the European Union and the Arab League, as well as the global powers, have failed to solve the Syrian crisis (Göker & Keskin, 2015), which started with public demonstrations in March 2011 and became a civil war (Semin, 2015: 1). Thus, the last stop of the revolt in the Middle East was Syria (Orhan, 2011). Terrorist organizations have been produced in the region by the authority gap and the arming of the great states. It is known that one of these organizations, Deas, has captured a large number of women in northern Syria and Iraq, sold most of them or forced them to marry, and these women and their little girls were raped (Puttick, 2015).

Since the beginning of the war in Syria, where torture and ill-treatment in prisons has been out of control, more than 120,000 people have been imprisoned or lost, and at least 12,000 people have been killed in prison. More than 20,000 children have lost their lives in the country where chemical weapons, marble and barrel bombs are used. One third of the houses and the half of the hospitals and educational institutions were destroyed in Syria, where a great deal of destruction and victimization were experienced under the conflict of interests of global powers (IHH Syria Annual Report, 2017).

In March 2015, Saudi Arabia and members of a coalition it established (hereinafter referred to as the Saudi-led coalition) launched a military operation aimed at restoring the rule of Yemen's internationally recognized President Abdu Rabbu Mansour Hadi (Sharp, 2017). There is a power struggle in Yemen due to regional interests between Saudi Arabia and Iran. Ülke'de İran destekli hükümet karşıtı Husiler ile Suudi Arabistan'ın desteklediği hükümet güçleri arasında savaş devam etmektedir. Yemen people pay the price of this war Because of the embargo of Saudi Arabia in the country, millions have been left with hundreds of hunger, thirst and illness (Salisbury, 2015).

Civil War and Health

One of the most well-known and popular definitions of health is the definition of the World Health Organization. Health) A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity state (WHO, 2014). According to the Biomedical Model; biological self-health is evaluated as healthy state and disruption of this balance is considered as a disease or medical condition (Pearson et al., 2005: 44). According to Bircher (2005: 336) the health; Age is a dynamic well-being characterized by a physical, mental and social potential that meets the demands of life in proportion to culture and personal responsibility. It is a condition where the potential is not sufficient to meet these demands. Baudrillard (2010: 177) emphasizes the social determinants of health and defines the healthİ "Health is a social command based on status rather than a biological command that is bound to survival today. Health is more of a burden than a basic value."

It seems rather vicious and meaningless to draw the concept of health for the people who resist to death in the geographies where war and brutality prevail. What does health mean for a helpless Syrian woman who has no home or her goods, who has lost her children and husband and has been raped, and starving Yemeni child? The explanation of the meaning of health for the people of these two countries, who are living their lives biologically, with pain, trauma and meaningless, do not seem possible.

Findings

The distribution of the news examined between 1 September 2017 and 31 December 2017 is given in Table 1.

Table 1: *Distrubition of News by Months*

Months	**News Numbers**	**%**
September	17	13,9
October	18	14,8
November	30	24,6
December	57	46,7
Total	122	100

As seen in Table 1, the number of news stories in Syria and Yemen increased towards the end of the year. It can be concluded that more real events (explosion, conflict, negotiation, attack, explanation, etc.) related to civil war have taken place as of 2018.

In the study, basically 4 basic dimensions were obtained.

Table 2: *Main Dimensions*

Dimensions
1. Efforts
2. Problems
3. Attacks
4. Massacres

1. **Efforts**

Efforts; It consists of all kinds of actual or verbal attempts made or planned for Syria and Yemen. This dimension consists of 3 categories:

1.Turkey's efforts

2.International efforts

3. Local efforts in Syria and Yemen

2. **Problems**

The problems point tothe war and any material and spiritual problems that come with war. The problems were categorized under 4 headings. These are:

1. Economıc problems
2. Social problems
3. Pshchological problems
4. Child problems

3. **Attacks**

Attacks: Express the attacks against the civilian and vulnerable people made by the coalition forces, government forces, terrorist groups and the countries that support them with all kinds of weapons and war vehicles.

The attackers are also classified under 4 headings.

1. Attacks on health ınstitutions
2. Attacks on public spaces
3. Attacks on ivil defence team
4. Attacks on religious minorities

4. Massacres

Massacres: It means the collective death of a group of civilians at the same time in result of any kind of attack. These massacres are carried out especially with bombs and chemical weapons throwed out from planes. The UN has not had any sanctions against the regime for the use of chemical weapons. Types of massacres are listed below:

1. Chemical weapons
2. Heavy weapons
3. Torture
4. Suicide

Conclusion

Since the last century in the history of the Middle East, drama, savagery and massacre social traumas have never ended. Still, it does not seem to end. The biggest indescribable pain is suffered by innocent civilians. The fact that the permanent members of the United Nations Security Council (USA, France, Britain, China and Russia) did not take concrete steps to solve the Syrian crisis allowed the Assad regime to carry out major massacres in the civil war in the country (Semin, 2015: 2). Hundreds of health centers and hospitals have been destroyed due to bombings, and doctors have died. Because of non-medication, operations have been performed without sedation (IHH Syria Annual Report, 2017: 27). Hundreds of thousands of people who are unable to meet basic requirements such as food, water, electricity, fuel and

medical supplies in Yemen and Syria due to the war; struggles for survival in hunger, disease and poverty (Çevik, 2016: 82). In Syria, the women captured by the ISIS terrorist organization are raped and sold. It is reported that there are people who died from torture in the regime's prisons. Chemical attacks were carried out hundreds of times by the regime forces. In Yemen, starving babies and children die before the world. Nearly 8 million people are deprived of basic foodstuffs. Although there is limited international assistance, it meets the needs of very few people. Sometimes these aids cannot reach those in need.

Various definitions have been made by the world health organization and different authors about the concept of health. However, it is thought that these definitions in the war environment could not reveal a descriptive and diagnostic situation for oppressed and victimized civilians in the disease-health axis. Due to the fact that many traumas and pain cannot be described and explained, it is not possible to limit the health-disease severity of these people. How the health-disease definition can be explain in the condition of people whose wife, mother, child and brother have been killed, who were wounded by the bombs and bullets that they dont know where it comes from, who were starved, raped, tortured, abducted, and enslaved?

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THE ROLE OF WRITTEN PRESS IN AGING AGAINST AND AGING

Mehtap Ataseven Bulun[1], Erdinç Ünal [2]

Abstract

Anti-aging is a rapidly growing social movement in society. The negative attitude towards old age, which is one of the normal life periods, has been developed, and therefore the media has an important role in mediating old age. The purpose of this study is to make a qualitative analysis of the rhetoric about the aging of the written press and to identify the messages given to it through aging news. With this aim, 4 newspapers that have high circulation in Turkey at national level and one magazine's annual publication of to the period in 2016 were screened retrospectively and identified 248 articles were taken into study. The texts and images of the news were analyzed by content analysis method. According to the findings of the study, the most mentioned issue in the news texts is that the aging can be prevented. The most common themes are aging-related risks and commercial direction of anti-aging. Nutrition and medical aesthetic applications come to the forefront among the anti-aging practices recommended by the news.

Keywords:

Medicalization of aging, Anti-aging, Media and aging

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[1] İstanbul Okan University, İstanbul,Turkey
[2] İstanbul Okan University, İstanbul, Turkey

Introduction

The function of anti-aging products and applications in everyday life is gradually increasing. One of the most important reasons for this increase is health news published via various media tools. It is frequently emphasized that benefiting from applications and practices developed in a highly profitable sector that can be called healthy life industry is a necessity to be "healthy", also these applications and practices make an individual look young and physically-fit. Thus, it leads to medicalization of aging and making people perceive aging as a condition that is a negative and diseased phase and that needs to be delayed and even to be avoided.

Monitoring the old age and course of life with a disease perspective results in regarding aging process as a closed and controlled situation. This type of approach is contrasted with the concept of "successful aging", which is defined by objectives such as continuation of social relations, taking preventive measures for health problems and approaching life positively. Estes and Binney (1989) indicated that this approach will strengthen "stamping" tendency that is widely seen in society concerning the aging people. The belief in curableness of aging prevents the understanding of social and biological dynamics related to aging person that deeply shaping the old age period (Turkish Public Health institution, 2015).

Trends in medicalization of aging have become more prominent in recent years. According to a study conducted in 2000, 30% of Americans aged 65 and above (10 million Americans) use alternative medicine for aging-related effects (Foster et al., 2000). Developments in the fields of medical sciences and clinical intervention have changed nature of life, especially in advanced ages, in a way that is individually and socially unpredictable. Medicine produces a rhetoric promising that both aging can be prevented, and life can be extended. Today, the relationship of an individual with its body and aging has been transformed, the body has become open to unlimited manipulation at any age and the effect of health authorities on life has increased. Nature of the old age has also changed greatly through clinical practices and medical innovations. Existence of therapeutic interventions has revealed expectations for improvement in terms of effects of aging and increased quality of life, as well as increased the desire to sustain life at the highest level (Kaufman et al., 2004; Rose, 2001).

In consumer society, medicine focuses on "later life effect of middle age" and tends to reconcile the risks of old age to middle ages. Individuals, usually around 55 years, are considered as "grey gold" by various sectors due to leisure time and economic levels increased with retirement. This so-called "ageless" elder market, created by sectors such as cosmetics, fashion and entertainment, redefines aging through bodily pleasures and identities (Katz et al., 2003).

"As the aging is medicalized; natural consequences of aging such as wrinkles, skin sagging and hair loss are incorporated into the subject of medicine; they have become problems that need to be corrected" (Sezgin, 2010). Bodies are subjected to numerous interventions to make their appearance aesthetic, thus to prevent, slow down or eliminate effects of aging. Individuals consult to doctors for these purposes and demand "anti-aging" applications.

This study aims to make a qualitative analysis of the rhetoric of printed press and to identify messages given to the community in this direction through news of aging.

Purpose

The research was designed in descriptive model. News on aging in four newspapers (Sabah, Posta, Sözcü, Hürriyet) and a magazine (Cosmopolitan) that have the highest circulation at national level in Turkey constitute the scope of research.

News published by these newspapers and the journal in a 1-year period between January 1, 2016-December 31, 2016 were retrospectively scanned with the keywords "aging", "old age" and "anti-aging", and 248 news directly about aging were included in the research.

These 248 articles were examined with content analysis method. Reliability of the content analysis technique depends largely on coding process. What is expected from this process is that inter-encoder adaptation rate is higher than 70% (Tavşancıl & Aslan, 2001). For this reason, after creating themes and categories, internal reliability analysis regarding content analysis was conducted. In an analysis conducted over the first 100 news by the researcher and an independent encoder, inter-encoder compatibility was found as 86%, and internal reliability was determined to be high. Descriptive analyses (frequency and cross tables) for code frequencies, themes and categories were conducted with SPSS 22.0 package program.

Findings

A total of 248 news detected in an annual period between January 1, 2016-December 31, 2016 were examined. Most of these articles belong to Sabah Newspaper with a rate of 53.2%. Subsequently, it was determined that 18.5% of news were published in Sözcü Newspaper; 10.5% of them in Posta Newspaper, 10.1% of them in Cosmopolitan Magazine, and 7.7% of them in Hürriyet Newspaper.

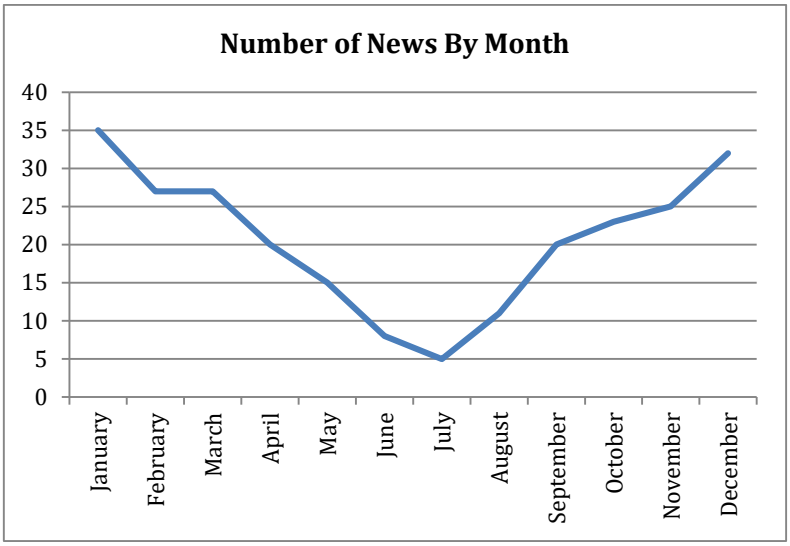
Table 1: Distribution of Articles by Media Organ

Name of Newspaper-Journal	Frequency (f)	Percentage (%)
Sabah	132	53.2
Sözcü	46	18.5
Mail	26	10.5
Cosmopolitan	25	10.1

Hürriyet	19	7.7
Total	248	100

Analyzing the graphical trend of news numbers, it can be seen that intensity of news varies seasonally, and the number of aging news in the summer period has fallen considerably.

Figure 1: Number of News By Month



Analyzing the repetition of articles, i.e. the publication of the same content in multiple newspapers or magazines, it was determined that most of the articles were the first publication (f:226, 91.1%). Among these articles, 46.8% of them are articles; 31.9% of them are health corners, 16.1% of them are interviews; 5.2% of them are columns.

Table 2: Type of Article

Article Genre	Frequency (f)	Percentage (%)
News	116	46.8
Health Corner	79	31.9
Interview	40	16.1
Column	13	5.2
Total	248	100

When origin of articles are examined, it is seen that 63% of them do not show any sources. 18.1% of articles belong to a columnist and reporters. 15.7% of articles have shown a domestic news agency as a source; 2.4% of them have shown another magazine and newspapers as a source.

Table 3 Article Source

Country of Origin/Source	Frequency (f)	Percentage (%)
Without sources	158	63.7
Columnist/Reporter	45	18.1
Domestic Agency	39	15.7
Other Magazines and Newspapers	6	2.4
Total	248	100

Texts are classified thematically under 7 headings. **Theme of aging-related risks** includes news about the risk of aging and the risks acquired by aging. The suggestions for self-evaluating by a person by giving symptom-findings, treatment and etiological factors of any diseases are classified under this theme. **Self-control theme** contains news that include healthy life news and suggestions for lifestyle regulation of a person. Under this topic, individuals are informed about what to do to be healthy, fit and have a long life. News related to commercial products and guiding towards services are coded under **commercial routing theme**; news giving food and nutrition recommendations are coded under **food/nutrition/vitamin suggestion theme**; news promoting anti-aging processes and procedures are coded under **process/procedure definition theme**; news about aging experiences of celebrities are coded under **aging experience in celebrities theme**; and news about research findings are coded under **anti-aging research findings theme**. It can be seen that risks associated with aging theme (f:67%, 27) is the most repetitive theme. The least compared themes are aging experiences in celebrities theme that contains news about aging experiences (f:9, 3.6%) and research findings that provide information on scientific studies (f:9, 3.6%).

Table 4: Article Theme

Theme	Frequency (f)	Percentage (%)
Aging-related risks	67	27
Commercial routing	63	25.4
Food/Nutrition/Vitamin Recommendation	49	19.8
Process/Procedure Promotion	30	12.1
Self-control	21	8.5
Aging Experience in Celebrities	9	3.6
Anti-Aging Research Finding	9	3.6
Total	248	100

Considering classification of articles based on context of aging, it is determined that 45% of these articles are about preventability of aging; 23% of them are about loss of beauty with aging; 23.8% of them are about aging causing diseases; 2.8% of them are about exclusion from society with aging; 2.4% of them are about importance of healthy aging; 1.2% of them are about retirement and loosing of job; and 0.8% of them are about subject of aging and death.

Table 5: Context of Aging

Context	Frequency (f)	Percentage (%)
Preventability/Prevention of Aging	113	45.6
Loss of beauty	58	23.4
Cause of diseases	59	23.8
Exclusion from society	7	2.8
Healthy aging	6	2.4
Retirement/Loosing Job	3	1.2
Death	2	0.8
Total	248	100

Chi-square test was applied for the relationship between context of aging emphasis and content of articles. Accordingly, there was a statistically significant difference between context of aging emphasis and making commercial suggestions in content of articles ($p<.0001$).

Table 6: Cross-table of Context of Aging Emphasis and Commercial Suggestion

Context of Aging Emphasis	Commercial routing exits	No commercial routing	Total	P
Cause of diseases	19	40	59	<0.001*
Loss of Beauty	53	5	58	
Preventability of Aging	68	45	113	
Other	2	16	18	
Total	142	106	248	

*Pearson chi-square value

In articles reviewed, suggestions were made towards preventing aging. The frequency distribution resulting from categorical analysis of these suggestions is given in Table 7.

Table 7: Anti-aging Suggestions

Anti-aging Suggestion	Frequency (f)	Percentage (%)
Vitamin/Nutritional Support Product Suggestion	57	23
Medical Aesthetic Suggestion	52	21
No Suggestions	47	18.9
Lifestyle Change	46	18.5
Cosmetic Product Suggestion	19	7.7
Plastic Surgical Application Suggestion	19	7.7
Check-Up/Examination Suggestion	6	2.4
Natural/Organic Product Use	2	0.8
Total	248	100

Analyzing anti-aging suggestions in articles respectively; it is determined that 23% of articles give vitamin nutritional suggestion; 21% of them give medical aesthetic suggestion; 18.5% of them give suggestion for lifestyle change; 7.7% of them give suggestion of using cosmetic product; 7.7% of them give suggestion of plastic surgical application; 2.4% of them give physician examination or check-up suggestion; and 0.8% of them give suggestion towards use of natural organic product. In 18.9% of news analyzed, no suggestions were given.

Examining articles in terms of visual use, it is determined that 73.8% of them include visuals, and 26.2% of them do not include any visuals. Since articles with images contain various visual contents, they were examined under a separate category. After the review, visuals were divided

into 5 categories. Visuals were collected in 5 categories, including human image, pharmaceutical image, nutrition or food image, nature and soil image, and mixed content containing a combination of several contents. Frequency distribution related to categories is presented in Table 8.

Table 8: Image Content

Image Content	Frequency (f)	Percentage (%)
Human	148	80.9
Food/Nutriment	20	10.9
Mixed	11	6
Nature/Soil Theme	3	1.6
Medication	1	0.5
Total	183	100

Analyzing images used in the articles; it is determined that human theme was used in 80.9% of these articles; drug theme was used in 0.5% of them; food and nutriments were used in 10.9% of them; nature and soil theme was used in 1.6% of them; and mixed images were used in 6% of articles. Classification applied on gender selection in human images is given in Table 9.

Table 9: Gender in Images

Gender in Images	Frequency (f)	Percentage (%)
Female	118	80
Male	30	20
Total	148	100

Among 148 human images examined, 118 of them include female (80%) and 30 of them include male (20%) in gender. Distribution of ages among individuals used in the images is given in table 10.

Table 10: Age periods in images

Age in Images	Frequency (f)	Percentage (%)
Young	94	63.5
Mixed	33	22.3
Elder	21	14.2
Total	148	100

In terms of age periods, it is determined that 63.5% of articles contained images of young people, 14.2% of them contained images of elderly, and 22.3% of them contained images with both young and elderly people.

Target audience of articles were categorized by assessing content of article and its images together. Frequency distribution related to this analysis is presented in Table 11.

Table 11: Target Audience

Target Audience	Frequency (f)	Percentage (%)
Female	160	64.5
Male	33	13.3
No gender discrimination	55	22.2
Total	248	100

Analyzing article contents and images together, target audience constitutes of female readers for 64.5% of articles, and 12.3% of articles target male readers. 22.2% of the articles and images examined target all readers without gender discrimination. It can be said that anti-aging news targeted towards females are higher in number. It was analyzed using Pearson chi-square test whether commercial routing was different as per gender (Table 12), and statistically significant difference was found (p<.001).

Table 12: Target Audience and Commercial Suggestion Cross Table

Target Audience	Commercial routing exits	No commercial routing	Total	P
Female	97	63	156	
Male	13	20	33	<0.001*
No gender discrimination	42	13	59	
Total	152	96	248	

Conclusions

When articles in printed press were examined in the study, it was determined that mostly **news type** (46.8%) articles were included, and majority of these news (63.7%) was published without giving any sources. It was observed that number of anti-aging news varied **seasonally**, and the number of news considerably decreased in the summer. This situation is in compliance with lack of preference towards medical treatment applications during summer.

Analyzing themes of news, it was observed that the most frequent recurring themes included **risks associated with aging** (27%) and **commercial routing** (25.4%). In terms of news contexts, it was determined that mainly subjects were discussed such as **preventability of aging** (45.6%), aging as **the cause of diseases** (23.8%) and **loss of beauty with aging** (23.4%). There was a statistically significant correlation between the context of aging emphasis and commercial suggestion (p<0.05). As revealed by the results of media analysis, **commercial routing** was made in one out of every four aging news.

In anti-aging news, **visual elements** were used extensively (73.8%). For this purpose, mostly **female and young** individual images were used in articles. Examining the action situation in images, it was determined that mostly skin analysis and care/treatment application for the skin were performed. Analyzing news according to their target audience, it was determined that news targeted **females** with a rate of 64.5%, and there was a statistically significant correlation between news towards female and commercial suggestions (p<0.05).

Today, perception of refraining from aging and physical practices to conceal signs of aging are widely applied. Wide use of “youth”, “subtlety” and “beauty” images by the media influences

individuals' perception of normality. The "old age" period, which can be seen as deviation from normal, has obtained characteristics of a disease that must be prevented by any means, tools or applications In the formation of such orientations, ideal body prototypes imposed by capitalist market economy and body paradigm of current period can be said to be effective. By providing a positive understanding of presentation of aging, the media can provide support for healthy aging in society. In news published in the media on the subject of aging, a supervision mechanism should be established towards making publications in accordance with "Healthy Aging Action Plan" strategy, which is also published in Turkey, in accordance with WHO suggestions. Especially in the media, idealized aesthetic emphasis should be avoided, and a self-control mechanism should be operated towards balanced use of aging and images related to elderly individuals.

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THE EFFECT OF COMMUNICATION PROCESSES IN THE RADIOLOGY DEPARTMENT OF HEALTHCARE ORGANIZATIONS ON DEPARTMENTAL COMMITMENT

Salih Kasap[1], M.Süheyl Pozantı [2]

Abstract

In hospitals and healthcare organizations, communication is very important for the processes related to patients and between them. In a department where technology is intensively used, such as radiology, smooth functioning of the patient-related processes is directly related to the success of communication. In addition to the importance of communication processes, workers' organizational and departmental commitment is key to medium and long-term planning. Workers' productivity and compliance with the organizational culture are the main indicators of department success. In this study which is the subject of this article, the examination of the communication processes between the radiology department workers and the effects of the communication levels on the workers' departmental commitment was performed. The study was carried out with the participation of radiology department workers in different healthcare organizations. Two different surveys were conducted on communication and departmental commitment. The data were analyzed independently and comparatively. Demographic features of the participants and information about working conditions were learned, and different analyses and comparisons were made with these data.

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Keywords:

Radiology, Communication in Healthcare,Organizational (Departmental) Commitment

This study was derived from the master's thesis entitled THE EFFECT OF COMMUNICATION PROCESSES IN THE RADIOLOGY DEPARTMENT OF HEALTHCARE ORGANIZATIONS ON DEPARTMENTAL COMMITMENT of Beykent University, Institute of Social Sciences, Department of Business Administration, Department of Hospital and Healthcare Management.

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[1] Özel Afiyet Hospital, Head of Radiology Unit, Master's Degree in Beykent University, Department of Hospital and Healthcare Management,salihkasap37@gmail.com
[2] Asst. Prof. Dr., Beykent University, School of Health Sciences, sppozanti@yahoo.com

Introduction

Communication is shown as the most prominent concept today for success and efficiency in hospitals and similar healthcare organizations. When communication in healthcare organizations is mentioned, communication with patients and their relatives is understood, but the communication process between the workers of the organization should also function smoothly for the success of this process. In addition to successful communication, this situation is expected to be long-term and to be identified with the organizational structure. The concept of organizational commitment appears at this stage. Organizational commitment or long-term relationship between workers and organizations will ensure that communication processes will both improve and prevent problems that may arise from differences.

The importance of correct communication will be better understood by considering that procedures in radiology are carried out with a device and patients are alone at this stage. Communication between the department workers is very intense with the effects of technology-based works and different job descriptions. Even if there is a similarity in the level of education and experience of workers, the workers need a significant adaptation period due to device differences and functions in the department. Consequently, it is aimed that the workers identified with the department as a result of a certain effort have a commitment on an organizational or departmental basis and maintain their job for a long time.

Nowadays, the way to compete is to seek ways to avoid losing successful workers. It is very clear that the most important investment is human resources. In this study, the departmental communication processes and the effects of these processes on departmental commitment are examined.

RADIOLOGY DEPARTMENT

Structure and Features of the Radiology Department: Radiology is defined as the department where technology is most intensively used. The basis of radiology is the images obtained by using X-rays. The images, also directly called radiograph, are now used as the primary diagnostic method. A more advanced device in the same system is called Computerized Tomography. Other systems that work with X-rays are Mammography, Angiography, Fluoroscopy, and Mobile X-ray devices. MRI and Ultrasonography devices work with magnetic systems and sound waves, respectively. Apart from interpreting the images, interventional procedures are also used for diagnosis in radiology. Interventional radiology procedures are also applied in the field of treatment. The radiology department

works very closely and cooperates with the departments of Nuclear Medicine and Radiotherapy in different diagnostic and treatment processes, especially PET/CT. Although radiological procedures are carried out mainly within the department, service is provided in different parts of the hospital with intraoperative MRI in the operating room and with mobile x-ray for hospitalized patients. Close cooperation with patients is required before and during the examination with devices using different technologies such as X-ray devices and MRI. The success of physicians, technicians, and nurses in managing processes such as posture, function, and perception depends on successful communication. Similarly, intensive cooperation and communication in the department and between the departments are also necessary for appointment, registration, patient preparation, imaging, and reporting processes.

Features of radiology department workers

Different professional groups work together in radiology. The procedures carried out only by radiology technicians in previous years are now carried out by a team of radiology specialists, radiology technicians, nurses, rapporteurs, registrars, patient consulting staff, assistant staff and cleaning staff. Workers of the department show a rich diversity in terms of education and quality. The prerequisite for their ability to work in harmony is primarily the correct communication between them.

Units with which the radiology department communicates within the hospital: Workers of the department primarily communicate with biomedical, information processing, human resources, quality, patient rights, archive, pharmacy, medical equipment and consumables warehouse, technical support units, telephone central workers during the day. Nurses and technicians working in clinical units such as operating rooms, intensive care units, emergency, and inpatient units are also healthcare workers who are in intensive communication with radiology. With image transfer, radiologists and clinical physicians can also access the images outside the radiology department. Image transfer can also be performed out of the organization if necessary. Although this situation has reduced the face-to-face communication of physicians with radiology workers, communication continues by telephone and other technological methods.

Institutions and organizations with which the radiology department communicates outside the hospital: Radiology workers are also in contact with certain people outside the hospital. These mainly include electronic and biomedical engineers and technicians related to the devices in the department. Radiology devices have different features today, so different engineers are responsible for the devices. This situation can reduce communication between the department and the device company directly to the communication between the related technician and engineer. Furthermore, image storage

and transfer are carried out by different companies, where it is a necessity to work in communication with both device manufacturers and department workers. Intensive communication is provided with the workers of device companies, not only in the case of failures but also during the device installation, updating, routine maintenance, and renewal stages. In addition, it is necessary to communicate with contrast material companies that help to obtain images. In this way, the department works continue without interruption or with minimal interruption. The radiology department is in intensive communication with TAEK. Device installation and audits are carried out with this communication and cooperation.

Communication features of the radiology department:

Communication Processes: In the radiology department, communication is carried out mainly in two processes. The first one is communication between the department workers, and the second one is communication between the department workers and patients. The communication of radiology workers with other workers of the organization and with external workers should be considered within the scope of communication between the workers. The subject of the study is the examination of the communication processes within the department. The effective and efficient functioning of this process will naturally affect communication with the patient positively. In the radiology department, it is assumed that communication between patient relatives and workers is lower than the other departments of the healthcare organization. This is caused by the fact that no person other than the patient should be present in the same environment due to radiation or magnetic field during imaging, examination or operation. Communication of the department workers with medical companies, engineers and workers of institutions such as TAEK, which are in contact with the radiology department, is defined as non-departmental communication.

Communication Channels: Radiology department communication channels can be examined in three groups as formal, informal and external communication channels. Formal communication is a type of communication within the unit and the department as well as between the statuses. It is examined in two main structures as vertical and horizontal communication. Vertical communication establishes a connection between the staff at the lowest level and the director at the highest level. In line with the hierarchical organizational structure, vertical communication from top to bottom and from bottom to top is carried out. The process is carried out by telephone, Intranet, e-mail, face to face and similar methods. Instructions, announcements, performance notices, suggestions and wishes are communicated by vertical communication. There may be disruptions in the vertical communication processes in both directions due to individual and environmental obstacles. Horizontal communication is the communication between people who are not in the superior-subordinate relationship with each other. Horizontal communication is imperative for works to continue. When we look at the hierarchical structure of the radiology

department, it is observed that horizontal communication is intensive. Another intensive communication process in the radiology department is Cross Functional or Diagonal communication. Diagonal communication, also meaning complex, is a type of communication between people in different departments and at different levels (Kocabaş, 2005). When examined in terms of radiology, doctors in different fields can share their opinions and suggestions by exchanging information about patients' images and reports. On the other hand, for example, an orthopedist can call the radiology unit to request a radiograph in bed for a hospitalized patient in the service, and the same specialist can request that the report of an emergency patient be written by the medical secretary. By examining the other examples, the doctor or nurse in charge of the operating room may request that a radiology technician be assigned to the operating room during the day, depending on the operation of that day. Again, the intensive care doctor or nurse can call the radiology department and request a mobile x-ray. The hierarchical structure was not taken into consideration looking at all of these examples, and the information was exchanged, and the work was requested by direct contact. There is no inconvenience in the exchange of information on specific subjects and the establishment of diagonal communication based on work between the departments. The process may cause irregularities in the organization if the department head and director, apart from the exchange of information, turn the communication into a form of ordering another department worker or if there is an unnecessary discussion. For this reason, unless required, organizations avoid using the diagonal communication channel in principle (Ada et al., 2008).

Open Communication: It is defined as Open Communication to provide communication in a healthy manner from bottom to top and from top to bottom. It may be necessary to communicate with people from different departments and positions at the same time within the organization (Dindaroğlu, 2007). If workers in an organization can easily share their thoughts and opinions, then there is open communication in that organization. In the organization where there is open communication, an organizational climate with low tension and high confidence, peace, and efficiency is created (Ekinci, 2006). There is clear and versatile communication in the radiology department. The department has to communicate with more than one unit, institution, organization, and individual. This process is required for the continuity of the department.

Informative (Educative and Instructive) Communication: The purpose of informative, educative and instructive communication is to transform the wide range of information into an appropriate form, to simplify and to convey it to the worker or customer. In the radiology department, the healthy imaging process and the duration of the examination are related to the patient's behavior. What needs to be done here is to inform the patient clearly and definitively about what should and should not be done before the examination. For example,

it is necessary to inform patients by giving information about the noises that may come from the device, that the imaging will be extended due to the slightest movement, and that the technician will observe him/her continuously.
It is also an informing method to show the patient what he/she needs to do in the form of a rehearsal, for example, the demonstration of how to apply the "take a deep breath and hold it" instruction. Apart from those mentioned, Evaluative (judgmental) communication, Influential (convincing) communication, Opinion and suggestion communication can be listed as other methods.

Informal communication: It is an informal and hierarchical communication method. It is an integral part of organizational communication processes, and many issues are discussed with this method.

External communication is examined as the communication between medical companies, engineers and institutions such as TAEK which are in contact with the radiology unit. It functions through social media as well as through individual channels. For this purpose, tools such as blogs, web pages, Facebook can be used.

Communication among Healthcare Workers: Concepts such as personal communication, communication in healthcare and empathy have come to the fore in recent years. As in every organization, special attention started to be paid to communication in healthcare in order to improve the quality of services in healthcare organizations. In order to provide a quality health service, workers need to have a high level of communication skills. With the desired quality of communication between healthcare workers, the desired level is expected to be reached in communication with the patient who is the main target. The communication of healthcare workers with the patient can be examined under the main headings of physicians, nurses, technicians, and assistants.

Physician-patient communication: It is a very important dimension of diagnosis and treatment. This communication process, which is established one-to-one and is compulsory in clinical medicine branches, is conducted differently in the radiology department. One-to-one communication in radiology is also experienced during ultrasonography and interventional procedures. In this communication, explanations of the physician to satisfy the patient's feelings, thoughts and curiosities will lead to the establishment of cooperation between the patient and the physician and to achieve healthier results (Voyvoda and Taşdemir, 2012).

Nurse-patient communication: An assistance relationship is established in nurse-patient communication, and communication techniques are used in defining problems and coping with stress. The most important factor that forms, shapes and directs care in nursing is

assistive communication (Tuna, 2014: 14). In the radiology department, the effect of vascular access which the nurse will open in the patient, the way he/she is affected by the procedure, information given about its level and its results can be shown as an example of relaxing communication.

Technician-Patient Communication: The radiology technician takes part in all examinations and procedures except for ultrasonography. He/she helps the physician in interventional procedures, and directly performs the procedure in other procedures. After the completion of the registration process of patients, the process is carried out with technicians, and during this period, continuous communication is carried out on the issues such as information about the procedure, posture, desired movements, procedure duration, and interactions. Radiology can be defined as the department where patients are communicating intensively with technicians.

Communication Between the Patient and the Administrative and Assistant Staff: Patients communicate with workers who perform different tasks in the processes such as registration, queue, direction to the procedure area and, if necessary, carrying. The importance of these workers in communication processes will be better understood by considering the mental situations of patients such as anxiety and fear.

Communication with Patient Relatives: There is constant two-way communication between patients and their relatives and hospital workers. Satisfaction of the patient also causes the relatives of the patient to be satisfied.

Communication Between the Hospital Management and the Patient and Patient Relatives: In addition to adequate technological devices, modern physical conditions, and a clean appearance, it is observed that quick access at the time of need is also important for the satisfaction of patients and their relatives. Therefore, interest, courtesy, respect, smiling face, reliability, communication, competence, flexibility and accessibility increase the satisfaction of patients and their relatives in a healthcare organization (Şahin, 2005). Patient satisfaction is recognized as a very important concept, and organizational studies are carried out in this respect.

Behavior Attributes in Communication Between the Patient and Patient Relatives and Healthcare Workers: Some common concepts were defined in this process. The main headings can be listed as Interest, Patience, Smiling Face, Tolerance, Respect, Equal treatment, Gaining trust, Reducing stress, Helping, Empathy, Unprejudicedness, Non-discrimination, and Image. As can be understood from the meanings of the concepts, relieving the worries and fears of patients and their relatives, and gaining their trust in the

organization and its workers are the main themes of the communication processes in this field.

Patient Rights and Occupational Ethics: When the rights of patients are observed in terms of patient rights, laws, regulations and occupational code of ethics, communication is carried out smoothly, and patient satisfaction is positively affected by this situation.

OrganizationaL (Departmental) Commitment Features

Organizational (Departmental) Commitment means that individuals come together voluntarily to achieve a goal and target, and desire to become a permanent worker of the organization (department) in order to achieve this goal or target (Başyiğit, 2006). The concept of organizational commitment and its understanding are the way of expressing the feelings of social instinct that exist in every place where there is a sense of society. In other words, although it shows the psychological approach of the worker towards the department, it is an expression of the psychological situation that affects the decision to work in the organization (Aygün Tüzün, 2013). Organizational commitment is the harmony between the individual and the organization. Organizational commitment means the identification of the worker with the organization or department. The worker's view of himself/herself as a part of the organization or department means that he/she does more for the organization, makes more sacrifices, and does not want to leave the organization or department (Erkmen and Çerik, 2007). According to Meyer and Allen, organizational commitment expresses the psychological behavior of the individual towards the organization. It is a psychological behavior that reflects the relationship between the individual and the organization and directs the decision to continue working in the organization (Çöl, 2004). The definitions made in the literature summarize the definition of the concept of organizational commitment as follows: Workers' wish to remain committed to the organization, the total efficiency of the organization, the identification with its success and interests, the individual's attitude towards the organization, and the self-sacrifice for the success of the department or organization (Aygün Tüzün, 2013).

The importance and benefit of organizational (departmental) commitment: It is possible to explain the importance of organizational commitment in terms of workers. Workers devote more time and effort to turn their tasks and goals into action as their degree of departmental commitment increases. They remain committed to the organization and tend to establish a positive relationship with their organization. The benefits of workers' organizational or departmental commitment can be summarized as follows. Adoption of their department where they work will enable them to climb up career steps and reach their desired goal in a shorter time. The directors of the organization give privilege to successful workers in salary increases, promotions, advancement, bonuses, and premiums. These

privileges and rewards further increase the departmental commitment and motivation of the worker (Gökçe and Parsehyan, 2014).

Classification of organizational (departmental) commitment: The concept of organizational commitment shows some differences according to demographic features. Becker and Salancik's approaches reveal these reasons. It was emphasized in Becker's approach that leaving the organization would have a cost, while Salancik explained that organizational commitment was a result of the behaviors of the individual. Buchanan, Allen, and Mayer classified the concepts of organizational commitment differently. These concepts are defined as commitment to job or occupation, commitment to work and colleagues, loyalty and obedience.

Classification of Factors Affecting Organizational (Departmental) Commitment

Many factors affect departmental commitment. Factors such as individual features, demographic features, age, gender, marital status and working time of the worker can be effective.

Individual and Demographic Factors: In the examination of individual and demographic features, it is observed that the features such as educational level, age, marital status, gender, working time in the organization are effective. Age and working time, gender and marital status and educational level are defined as the main headings.

Organizational (departmental) – Functional Factors: These factors include role uncertainty, role conflict, superior-subordinate relationship, and the nature of the work.

External Factors: Competitors are one of the external factors. They are examined under the main headings of alternative job opportunities, specialty, and experience.

Organizational management factors: Management factors include wages policy, organizational justice, organization size, organizational teamwork, organizational culture.

Psychological factors affecting organizational (departmental) commitment: The way of percepting the working conditions of the department and the fair or unfair treatment of workers in the working environment is called a psychological factor. This psychological factor affects a worker's departmental commitment. In the studies on this subject, a positive relationship was found between justice and departmental commitment (Özdevecioğlu, 2003). If the worker believes that the promotion, salary, compensation and social rights are not distributed fairly by the management, the performance of the person decreases. As a result, a tendency to leave the department emerges. In the decision-making processes of directors, it is of great importance that workers think that the decisions are taken fairly. It

is very important that workers are given the right to objection and the opportunity to declare their opinion in the decisions taken. The cases mentioned may positively affect the workers' departmental commitment (Aygün Tüzün, 2013).

Relationship Between Organizational (Departmental) Commitment and Communication

The establishment of healthy communication within the department strengthens the sense of departmental unity and ensures that all workers feel themselves a part of the department. Thus, the commitment of all workers to the department is positively affected. Furthermore, organization information sharing is of utmost importance for workers to be identified with the organization. A comprehensive and descriptive communication program is an important force for the organization. In this way, workers know not only the current developments in the organization or department but also how the future work of the organization will affect their careers. Information sharing should not only be related to organization information or departmental structure but should also include technical information for the specialization. Monitoring technological developments and sharing information about the department are very important for the future of the organization (Çöllü and Summak, 2010). The adoption of a participatory and informative style by the management and the application of open communication in the superior-subordinate relationships increase the motivation of workers. Due to this positive communication process, workers become more efficient and perform better. As a result, the worker will become happier, he/she will be friendly to the patient, and his/her departmental commitment will increase (Ekinci, 2006).

Purpose

In the previous chapters, communication processes between all healthcare organization workers and radiology department workers were examined. These processes vary in comparison to the other departments due to the structural features of the radiology department and the differences in the worker profile. Technology-intensive work and radioactivity are seen as the prominent differences. Based on the fact that the radiology department has a unique structure due to the features mentioned, it is assumed that the organizational commitment of workers is also important. This study was conducted with the assumption that this commitment has a direct relation to the communication processes described previously.

Method

Study Design: The study was designed as a "screening model." The screening model is a research method that aims to show a situation that has occurred in the past or is still in progress as it is.

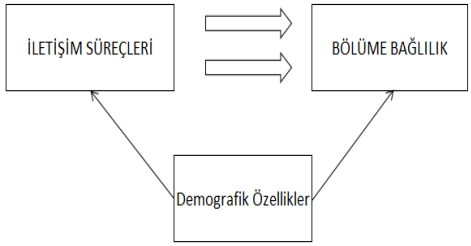

Figure 1. Study Design

Study Hypotheses: Three hypotheses described below were investigated.

H1: In the radiology department, communication processes have a variable effect on departmental commitment.

H2: In the radiology department, communication processes differ significantly according to demographic features.

H3: The rates of departmental commitment in the radiology department differ significantly according to demographic features.

Data Collection Tool

Communication Process Assessment Scale: There is a defined scale for the assessment of the communication processes, which is specific to the radiology department and of which literature reliability and validity are identified (Baş, 2001). The scale for the assessment of communication processes in the radiology department was developed by the researcher. When designing a Likert-type scale, firstly it is appropriate to perform a literature review and then to receive an expert opinion. The literature on the assessment of communication processes was reviewed, and an item pool of 31 propositions suitable for the radiology department was formed, and expert opinion was received. Reliability and validity studies were performed for the scale.

The exploratory factor analysis method was used to determine the structural validity of the scale. As a result of the test, it was determined that the sample size was sufficient to apply factor analysis. In the factor analysis application, it was ensured that the relationship structure between the factors remained the same by selecting the varimax method. As a result of the factor analysis, variables were grouped under 3 factors defined by Communication Quality, Attention in Communication, and Openness of Communication Channels. The "Cronbach's alpha," the internal consistency coefficient, was calculated to assess the reliability of the 20 items in the communication process assessment scale. The overall reliability of the scale was found to be very high with the Cronbach's alpha = 0.918. According to the alpha related to reliability and the variance value explained, it

was understood that the communication process assessment scale is a valid and reliable tool. The factor structure of the scale is presented below.

Departmental Commitment Scale: Allen and Meyer's organizational commitment scale was used to measure departmental commitment. The scale consists of 18 questions; the first 6 questions are related to emotional commitment, questions 7-12 are related to the continuity commitment, and questions 13-18 are related to normative commitment. In this study, the reliability of the commitment scale was found to be high with the Cronbach's alpha = 0.859.

Statistical Analysis of Data

The data obtained from the study were analyzed by using SPSS program. Number, percentage, mean and standard deviation were used as descriptive statistical methods. Scores of the scale dimensions were evaluated between 1 and 5. In order to calculate the distribution range, the formula of the distribution range = largest value - smallest value/number of degrees was used. The t-test was used to compare the quantitative data between two independent groups, and the one-way ANOVA test was used to compare the quantitative data between two independent groups.

Results and Discussion

A total of 267 radiology department workers participated in the study. In this section, there are the results of the analysis of the data collected through the scales from the workers who participated in the study in order to solve the research problem. Explanations and comments were made based on the results.

Distribution of Descriptive Features

Distribution of Demographic Features: The participants were examined according to the variables such as "Duty, Age, Gender, Working time in the occupation, Educational status, Working time in the organization, Number of different organizations served and Educational status on the communication in healthcare."

Opinions about Communication: In this section, the opinions of the participants about the five different variables were received. These variables are defined as the "Interpersonal Effective Communication Method, Devices Used, Incorrect Examination Due to Communication Failure, First Person Communicated in case of an Unknown Examination, Problems with the PACS (Image Transfer System) in the Organization."

Communication Process Assessment and Departmental Commitment Mean Scores

Communication Process Assessment Mean Scores: The levels of the workers who participated in the study regarding the "Communication Quality, Attention in Communication, Openness of Communication Channels and General Communication Process Assessment" were determined to be high.

Departmental Commitment Mean Scores: The levels of the workers who participated in the study regarding the "Emotional commitment, continuity commitment, normative commitment, and general departmental commitment" were determined to be **medium**.

Correlation Analysis Between the Communication Process Assessment and the Departmental Commitment Scores:

Table 1. Correlation Analysis

		Communication Quality	Attention in Communication	Openness of Communication Channels	neral Communication Process Assessme	Emotional Commitment	Continuity Commitment	Normative Commitment	General Departmental Commitment
Communication Quality	R	1.000							
	P	0.000							
Attention in Communication	R	0.590**	1.000						
	P	0.000	0.000						
Openness of Communication Channels	R	0.552**	0.422**	1.000					
	P	0.000	0.000	0.000					
General Communication Process Assessment	R	0.919**	0.827**	0.694**	1.000				
	P	0.000	0.000	0.000	0.000				
Emotional Commitment	R	0.282**	0.237**	0.336**	0.326**	1.000			
	P	0.000	0.000	0.000	0.000	0.000			
Continuity Commitment	R	0.146*	0.092	0.108	0.142*	0.160**	1.000		
	P	0.017	0.135	0.078	0.020	0.009	0.000		
Normative Commitment	R	0.230**	-0.035	0.287**	0.176**	0.339**	0.434**	1.000	
	P	0.000	0.567	0.000	0.004	0.000	0.000	0.000	
General Departmental Commitment	R	0.299**	0.135*	0.331**	0.293**	0.683**	0.724**	0.798**	1.000
	P	0.000	0.027	0.000	0.000	0.000	0.000	0.000	0.000

*<0.05; **<0.01

The Effect of the Communication Process on the "General Departmental Commitment": Regression analysis was found to be statistically significant. It was observed that the explanatory power of the relationship between the level of general departmental commitment and the variables of the general communication process assessment was weak. The level of the general communication process assessment of workers increases the level of general departmental commitment.

The Effect of the Communication Process Sub-Dimensions on the Dependent Variable of "General Departmental Commitment": Regression analysis was found to be

statistically significant in determining the cause and effect relationship between communication quality, attention in communication, openness of communication channels and general departmental commitment. As a determinant of the level of general departmental commitment, it was observed that its relationship (explanatory power) with the variables of communication quality, attention in communication, openness of communication channels was weak. The level of the communication quality of workers increases the level of general departmental commitment. The level of attention in communication of workers does not affect the level of general departmental commitment. The level of the openness of communication channels of workers increases the level of general departmental commitment.

The Effect of the Communication Process Sub-Dimensions on "Emotional Commitment": Regression analysis was found to be statistically significant in determining the cause and effect relationship between communication quality, attention in communication, openness of communication channels and emotional commitment. As a determinant of the level of emotional commitment, it was observed that its relationship (explanatory power) with the variables of communication quality, attention in communication, openness of communication channels was weak. The level of the communication quality and attention in communication of workers does not affect the level of emotional commitment. The level of the openness of communication channels of workers increases the level of emotional commitment.

The Effect of the Communication Process Sub-Dimensions on the "Continuity Commitment": It was found to be insignificant.

The Effect of the Communication Process Sub-Dimensions on "Normative Commitment": Regression analysis was found to be statistically significant in determining the cause and effect relationship between communication quality, attention in communication, openness of communication channels and normative commitment. As a determinant of the level of normative commitment, it was observed that its relationship (explanatory power) with the variables of communication quality, attention in communication, openness of communication channels was weak. The level of the communication quality of workers increases the level of normative commitment. The level of attention in communication of workers does not affect the level of normative commitment. The level of the openness of communication channels of workers increases the level of normative commitment.

Table 2. Comparison of the Communication Process Assessment According to Descriptive Features (communication quality, attention in communication, openness of communication channels and general communication process assessment)

	Group	N	Mean	Sd	F	p	Difference
2.1. The mean score of the communication process assessment according to the educational status was not found to be significant	Secondary Education and Lower	58	3.832	0.711	0.967	0.409	
	Associate Degree	130	3.864	0.721			
	Undergraduate Education	58	3.760	0.634			
	Postgraduate Education	21	4.052	0.508			
2.2. The mean score of the communication process assessment according to the duty was not found to be significant	Radiology Specialist	16	3.878	0.686	0.627	0.679	
	Technician	170	3.828	0.666			
	Nurse	14	3.707	0.721			
	Rapporteur	14	4.125	0.685			
	Consulting and Assistant Staff	45	3.881	0.779			
	Head of the Administrative Affairs Department	8	3.831	0.581			
2.3. The mean score of the communication process assessment according to the working time in the organization was not found to be significant	Less than 1 Year	44	3.931	0.877	0.941	0.441	
	Between 1-5 Years	115	3.866	0.655			
	Between 6-10 Years	45	3.713	0.591			
	Between 11-15 Years	33	3.953	0.664			
	16 Years and More	30	3.755	0.648			
2.4.1. The mean score of the communication process assessment according to the working time in occupation was found to be significant in terms of **the quality of communication**	Less than 1 Year	31	4.129	0.744	2.426	**0.048**	**1>4 1>5**
	Between 1-5 Years	82	3.854	0.738			
	Between 6-10 Years	54	3.794	0.841			
	Between 11-15 Years	39	3.595	0.728			
	16 Years and More	61	3.715	0.763			
2.4.2. The mean score of the communication process assessment according to the working time in occupation was not found to be significant	Less than 1 Year	31	4.129	0.720	2.097	0.082	
	Between 1-5 Years	82	3.866	0.672			
	Between 6-10 Years	54	3.843	0.716			
	Between 11-15 Years	39	3.664	0.663			
	16 Years and More	61	3.808	0.652			
2.5. The mean score of the communication process assessment according to the educational status on the communication in healthcare was not found to be significant	No, I didn't	66	3.864	0.665	1.437	0.232	
	I participated in organizational training	151	3.863	0.687			
	I received a certificate	25	3.976	0.675			
	I took it as a course at the university	25	3.598	0.732			
2.6. The mean score of the communication process assessment according to the age was not found to be significant	18-25	49	3.886	0.747	0.235	0.791	
	26-40	140	3.822	0.663			
	Above 40	78	3.875	0.696			
2.7. The mean score of the communication process assessment according to the healthcare organization served was not found to be significant	Private hospital	85	3.957	0.643	1.477	0.197	
	State hospital	81	3.809	0.598			
	Training and Research Hospital	54	3.681	0.701			
	University Hospital	20	3.793	0.926			
	Private Imaging Center	20	3.980	0.776			
	Medical Center	7	4.086	0.900			

2.8. The mean score of the communication process assessment according to the gender was not found to be significant	Female	162	3.860	0.705	0.328	0.743
	Male	105	3.832	0.660		
2.9. The mean score of the communication process assessment according to the number of different organizations served was not found to be significant	1-3	208	3.866	0.671	0.772	0.441
	4 and more	59	3.788	0.742		

The Mean Scores of the Communication Process Assessment According to the "Working Time in the Occupation": As a result of the one-way analysis of variance (ANOVA) performed to determine whether the mean communication quality scores of the workers participating in the study showed a significant difference according to the working time in the occupation, the difference between the group mean scores was statistically significant. A complementary post-hoc analysis was conducted to determine the sources of differences. The communication quality scores of those with less than 1 year of working time in the occupation were found to be higher than the communication quality scores of those with 11-15 years. The communication quality scores of those with less than 1 year of working time in the occupation were found to be higher than those of those with 16 years or more.

As a result of the one-way analysis of variance (ANOVA) performed to determine whether the mean scores of attention in communication, openness of communication channels and general communication assessment of the workers participating in the study showed a significant difference according to the working time in the occupation, the difference between the mean scores of the groups was not statistically significant.

Table 3. Comparison of Departmental Commitment According to Descriptive Features

(emotional commitment, continuity commitment, normative commitment, general departmental commitment)

	Group	N	Mean	Sd	F	p	Difference
3.1. The mean score of departmental commitment according to the educational status was not found to be significant	Secondary Education and Lower	58	3.226	0.563	0.417	0.741	
	Associate Degree	130	3.186	0.584			
	Undergraduate Education	58	3.147	0.541			
	Postgraduate Education	21	3.296	0.675			
3.2. The mean score of departmental commitment according to the duty was not found to be significant	Radiology Specialist	16	3.354	0.671	1.539	0.178	
	Technician	170	3.183	0.547			
	Nurse	14	3.095	0.606			
	Rapporteur	14	3.540	0.587			
	Consulting and Assistant Staff	45	3.122	0.624			
	Head of the Administrative Affairs Department	8	3.111	0.544			
3.3. The mean score of departmental commitment according to the working time in the organization was not found to be significant	Less than 1 Year	44	3.253	0.603	1.932	0.106	
	Between 1-5 Years	115	3.132	0.594			
	Between 6-10 Years	45	3.126	0.559			
	Between 11-15 Years	33	3.423	0.576			
	16 Years and More	30	3.204	0.439			
3.4.1. The mean score of departmental commitment according to the working time in occupation was found to be significant in terms of **emotional commitment**	Less than 1 Year	31	3.344	0.844	4.392	**0.002**	**1>2 3>2 5>2 5>4**
	Between 1-5 Years	82	2.986	0.716			
	Between 6-10 Years	54	3.380	0.734			
	Between 11-15 Years	39	3.158	0.823			
	16 Years and More	61	3.484	0.820			
	Between 1-5 Years	82	2.890	0.769			
	Between 6-10 Years	54	3.025	0.735			
	Between 11-15 Years	39	2.897	0.772			
	16 Years and More	61	2.934	0.836			
3.4.2. The mean score of departmental commitment according to the working time in occupation was not found to be significant	Less than 1 Year	31	3.283	0.578	1.649	0.162	
	Between 1-5 Years	82	3.061	0.600			
	Between 6-10 Years	54	3.262	0.545			
	Between 11-15 Years	39	3.246	0.559			
	16 Years and More	61	3.237	0.568			
3.5. The mean score of departmental commitment according to the educational status on the communication in healthcare was not found to be significant	No, I didn't	66	3.109	0.578	1.639	0.181	
	I participated in organizational training	151	3.213	0.562			
	I received a certificate	25	3.389	0.597			
	I took it as a course at the university	25	3.120	0.611			
3.6.1. The mean score of departmental commitment according to the age was found to be significant in terms of **emotional commitment**	18-25	49	3.095	0.795	9.810	**0.000**	**3>1 3>2**
	26-40	140	3.118	0.770			
	Above 40	78	3.571	0.753			
3.6.2. The mean score of departmental commitment according to the age was found to be significant in terms of **departmental commitment**	18-25	49	3.081	0.592	6.404	**0.002**	**3>1 3>2**
	26-40	140	3.129	0.576			
	Above 40	78	3.385	0.526			

3.7. The mean score of departmental commitment according to the healthcare organization served was not found to be significant	Private hospital	85	3.233	0.565	0.879	0.496
	State hospital	81	3.153	0.530		
	Training and Research Hospital	54	3.107	0.584		
	University Hospital	20	3.319	0.478		
	Private Imaging Center	20	3.342	0.769		
	Medical Center	7	3.119	0.809		
3.8. The mean score of departmental commitment according to the gender was not found to be significant	Female	162	3.146	0.573	-1.733	0.084
	Male	105	3.270	0.575		
3.9. The mean score of departmental commitment according to the number of different organizations served was not found to be significant	1-3	208	3.199	0.534	0.239	0.839
	4 and more	59	3.179	0.710		

The Mean Scores of Departmental Commitment According to the "Working Time in the Occupation": As a result of the one-way analysis of variance (ANOVA), the difference between the emotional commitment scores was statistically significant. The emotional commitment scores of those with less than 1 year of working time in the occupation were found to be higher than those with 1-5 years. The emotional commitment scores of those with a working time of 6-10 years were found to be higher than those with 1-5 years. The emotional commitment scores of those with a working time of 16 years and more were found to be higher than those with 1-5 years. The emotional commitment scores of those with a working time of 16 years and more were found to be higher than those with 11-15 years.

The difference between the mean scores of continuity commitment, normative commitment, and general departmental commitment was not statistically significant.

The Mean Scores of Departmental Commitment According to "Age": As a result of the one-way analysis of variance (ANOVA), the difference between the Emotional Commitment and General Departmental Commitment scores was statistically significant. The emotional commitment and general departmental commitment scores of those over 40 years of age were found to be higher than those between 18-25 years of age. The emotional commitment and general departmental commitment scores of those over 40 years of age were found to be higher than those between 26-40 years of age. The difference between the mean scores of continuity commitment and general normative commitment was not statistically significant.

Conclusion

In this study, the communication processes in the Radiology department, which is a department with intensive communication processes in hospitals and healthcare organizations, and the effects of these processes on departmental commitment were examined. Not only the communication processes of the radiology department workers with patients but also the departmental and organizational communication processes they carry out are important. The communication skills of the department workers as well as their organizational commitment and skills were evaluated. At this point, communication also gains importance in terms of organizational commitment.

267 individuals participated in the study. The participants were distributed as 162 females (60.7%) and 105 males (39.3%). These results show that females constitute the majority among the radiology department workers. According to demographic features, the majority ratios are distributed as follows. It is observed that technicians constitute the majority with 63.7% in the distribution of tasks, the age range of 26-40 with 52.4%, the working time of 1-5 years in the organization with 43.1%, and those with an associate degree constitute the majority with 48.7% in the educational status. The number of different organizations served was found to be 1-3 with 77.9%, the ratio of those who received training on communication in healthcare was 56.6%, and the ratio of those who did not receive training on communication in healthcare was 24.7%, which was quite high. This situation suggests that more organizational communication training should be provided. The preferences of the participants in interpersonal communication were determined as face to face communication with 95.9%.

In the answers to the questions about the devices, the question of used devices was answered as “all” with 65.2%, and this shows that the radiology department workers can work mostly on all devices. Although the question of incorrect examination entries was answered as “no” with 39.0%, it was observed that there was an incorrect examination entry ratio of 28.1%, which should be underestimated. It is understood that entries should be made more carefully. The question about the first person communicated in case of an unknown examination was answered as a responsible technician with 34.5% and as a radiology specialist with 33%. There was also an answer of “searching on Google” with 1%. The question about the problems with the pacs system in the organization was answered as 52.4%, and this situation shows a seriously high ratio.

A striking finding on the data obtained from the workers who participated in the study is that the participants' perceptions of communication quality, attention in communication, openness of communication channels, and general communication process assessment are “extremely high.” On the other hand, another noteworthy issue in the study was that the levels of emotional, continuity and normative commitment were evaluated as “average” in terms of the participants' organizational commitment. In other words, it is observed that the participants are in a state of uncertainty in terms of their organizational commitment.

When the effects of the communication process sub-dimensions on the general departmental commitment are examined, it is observed that the communication quality levels of workers and the openness of the communication channels in the organization increase the levels of the departmental commitment of workers. When the effect of the communication process sub-dimensions on emotional commitment is evaluated, it is observed that increasing the level of the openness of communication channels by themselves increases the level of emotional and normative commitment of workers. According to this, it is of great importance that participants increase their communication skills in the process and especially the openness of communication channels, in order to feel emotional commitment to their organizations.

The communication quality scores of those with less than 1 year of working time in the occupation were found to be higher compared to both groups with a working time of 11-15 years and above 16 years. Because of the fact that these workers are new in the sector, it is assumed that they pay attention to communication because they are inexperienced but have high expectations.

When the general communication process assessment ratios (communication quality, attention in communication, openness of communication channels) were examined, the scores of the workers who participated in the study were found to be high. Considering the reasons for the high scores, it should not be neglected that the communication training and organization training received by the person have an effect. Furthermore, it is thought that there are effects such as the intensity of internal and external audits, performance evaluations of communication and promotions related to it.

The general departmental commitment scores (emotional commitment, continuity commitment, normative commitment) were determined as average. Upon looking at the reasons for the average departmental commitment scores, it is possible to say that workers do not plan to do this in the long term and have different future plans.

When the effects of the communication process on the general departmental commitment were examined, it was found out that its relationship (explanatory power) with the variables of the general communication process assessment was weak. It is observed that the level of the general communication process assessment of workers increases the level of general departmental commitment.

When the effects of the communication process sub-dimensions on the “level of general departmental commitment” were examined, it was determined that its relationship (explanatory power) with the variables of communication quality, attention in communication and openness of communication channels was weak. It was observed that the level of the communication quality of workers increased the level of general departmental commitment, the level of attention in

communication did not affect the level of general departmental commitment, and the level of the openness of communication channels increased the level of general departmental commitment.

According to the descriptive features of the communication process (according to the educational status, distribution of tasks, working time in the organization, education on communication in healthcare, age, gender, organization and the number of organizations served), the difference between the group mean scores was not statistically significant.

When the mean scores of workers' departmental commitment are evaluated according to their ages, it is observed that the workers aged 40 and older have higher scores in terms of emotional, continuity and normative commitment. Accordingly, these workers are now able to consider organizational commitment in all dimensions as a result of their experiences in both individual life and professional life.

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MALAYSIA HEALTH SYSTEM REVIEW:

OVERVIEWS AND OPINIONS

Mehmet Yorulmaz[1], Nur Nabilah Mohamed[2]

Abstract

Objective: The aim of this study to describe the institutional framework of healthcare system, the process, content and healthcare expenditure spending within Malaysia.

Methodology: In these articles, all data are collected from books, articles, outlines sources and also from Malaysia National Health Account (MNHA) database.

Abstract: Healthcare in Malaysia was known by all of the country in the world in which healthcare sector plays an important role in giving a health service to all peoples. According to the World Health Organization (WHO), government and the private sector play a crucial role in providing a quality life for its citizen through the good health system. Back to this year 2018, the economic issue became an important role for each of country in order to manage a budget and to spend on citizens. Besides that, Malaysia's national healthcare expenditure was around 4.6 percent of GDP in 2015. In 2018, after the General Election, the new government was analysing all on-going budgets and future projects. The budget allocated is subject to change, in which Malaysia is more concerned on healthcare allocation of budget for these years. In which the Ministry of Health allocated 10.4 percent for the annual national budget and out of this allocation, 3.6 percent is assigned for healthcare expenditure. Regarding this issue, this article starts by introducing Malaysia country, healthcare system and healthcare spending in Malaysia.

Keywords: Government Sector, Private Sector, Healthcare Expenditure

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[1] Asist. Prof.Dr. Selçuk University, Health Science Faculty, mtyorulmaz@hotmail.com
[2] Master Student, Selçuk University, Health Science Institute, nurbiela_1993@yahoo.com

Introduction

1. History of Malaysia

In 1957, Malaysia country achieved an independent country after under British colonization it means that Malaysia country was free from conquering of any country. Malaysia is a federal state located in Southeast Asia and has two main areas separated by the South China Sea. Historically, the peninsula of Malaysia or formerly known as the Malay Peninsula was the main trading centre in Southeast Asia where at that time the state of Johor became a connection to India and China economically and became a stopover for traders from both countries. Malaysia was independent of the British rule on August 31, 1957, as a federal Malaya which is covering 11 states in the Malay Peninsula. In 1963, Sabah and Sarawak joined Malaya and at that time it was known as the Federation of Malaya. Malaysia is still practicing the parliamentary democracy and constitutional monarchy where the Yang di-PertuanAgong is elected every 5 years by the Malay Rulers Council. In 2019, Malaysia's population has become well-developed with 31.67 million. Moreover, healthcare system, good access in clean water and sanitation and programmes to reduce poverty, increase literacy, improve status of women and build a modern infrastructure has become more developed.

Geography and Sociodemographic

Table 1-1 Map of Malaysia

The Malays are divided into four main races namely the Malay-born bumiputras, which is called Malay which comprises 53% East Malaysia, which is also called the Borneo Earths which includes 10 percent, 27 percent of Chinese and Indians 10 percent. Meanwhile, the religion in Malaysia is Islam which covers 59 percent, Buddha 23 percent, Christian 10 percent, Hindu 7 percent, and Sikh 1 percent. If viewed in

terms of a racial and religious composition by society in Malaysia, it is evident that Malaysian society is a multi-racial society and known as a plural society. The unity and harmonious relationship between the races are crucial to the success of the multi-racial Malaysia. Thus, Malaysia's country is a multicultural and state with Sunni-Islam as the official religion. Besides that, according to World Bank classified Malaysia is an upper middle-income country but its society and economy were transformed by rapid economic growth latter half of the 21st century.

2. Historical Background of Healthcare System

The history of healthcare in Malaysia began before the time of independence. The construction of the hospital was there in order to treat workers that work in the tin mining industry. Each mine worker must pay 50 cents a year for treatment. In the 19th century, the tin mining industry flourished in Perak. Due to good achievement in the mining industry, the number of hospitals in the Perak's state was growing and number of hospitals become expanding until all the states in Malaysia.Healthcare in Malaysian has been characterized as a strong healthcare sector that everyone can access health services in Malaysia. One of the most things that accessible because of in here, the healthcare sector is governed by the public sector and the private sector. In other words, people here can access the health service by going to a public hospital or private hospital in getting treatment.Actually, there are three types of ownership distinguish hospitals in Malaysia. There are public hospitals, privately owned hospital and also non-profit private hospital.

3. Health Status

According to the Department of Statistics Malaysia, Malaysia had made great additions in life expectancy for its people; an increase year from 2011 to 2017 for male 72.1 to 72.7 years. However, life expectancy for women from 2011 to 2017 is 76.8 to 77.4 years. Thus, this figure reveals that there is an increasing number with 0.6 year for both male and female from years 2011 to 2017. Nevertheless, as Malaysia is a multicultural country, so there is figure life expectancy for all ethnicity. For example, the highest life of expectancy at birth for a male in 2017 is recorded by Chinese with 75.0 years while the lowest is recorded by Indians with 67.8 years. Then for females, the Chinese recorded the highest life expectancy at birth with 80.2 years while Bumiputra recorded with lowest in 76.2 years. Besides, for the mortality rate of in Malaysia now are come from communicable diseases to non-communicable diseases. According to from Department of Statistics of Malaysia, ischaemic heart diseases was the principal cause of death in 2016 of 13.2 percent, followed by pneumonia (12.5%), cerebrovascular diseases (6.9%), transport accidents (5.4%) and malignant neoplasm of trachea, bronchus & lung (2.2%).Then as statistics reveal that ischemic heart disease male reported as the highest of deaths. Meanwhile, the female reported the highest rise in pneumonia disease for the deaths.So, all the statistics can refer to Table 3-1 and Table 3-2.

Table 3-1 Statistics for Health Status

Land Area

Malaysia 330,713 sq. km Source : Department of Survey & Mapping, Malaysia

Population and Vital Statistics	2016			2015			2014		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total Population[a] ('000)	31,660.7	16,362.5	15,298.2	31,186.1	16,112.1	15,074.0	30,708.5	15,867.8	14,840.7
Population Density (per sq.km)		95.7			94.3			92.9	
Population by Age Group: [a] (number & percentage)									
• Below 15 years ('000)	7,763.3 (24.5%)	3,999.5 (24.4%)	3,763.8 (24.6%)	7,775.8 (24.9%)	4,002.1 (24.8%)	3,773.7 (25.0%)	7,773.6 (25.3%)	4,000.8 (25.3%)	3,772.8 (25.4%)
• 15 – 64 years ('000)	21,983.3 (69.4%)	11,436.0 (69.9%)	10,547.3 (68.9%)	21,589.0 (69.3%)	11,226.2 (69.7%)	10,360.8 (68.8%)	21,200.8 (69.0%)	11,028.0 (69.4%)	10,172.8 (68.6%)
• 65 years & above ('000)	1,914.1 (6.1%)	927.1 (5.7%)	987.0 (6.5%)	1,821.4 (5.8%)	881.8 (5.5%)	939.6 (6.2%)	1,734.1 (5.7%)	838.9 (5.3%)	895.2 (6.0%)
Annual Population Growth Rate (%)	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.7	1.6
Crude Birth Rate (per 1,000 population)	16.1	16.1	16.1	16.7	16.7	16.7	17.2	17.2	17.2
Crude Death Rate (per 1,000 population)	5.1	5.7	4.5	5.0	5.6	4.4	4.9	5.5	4.3
Stillbirth Rate (per 1,000 births)	5.2	5.2	5.2	4.4	4.7	4.1	4.3	4.6	3.9
Perinatal Mortality Rate (per 1,000 births)	8.3	8.5	8.1	7.7	8.3	7.1	7.4	8.1	6.6
Neonatal Mortality Rate (per 1,000 live births)	4.2	4.4	3.9	4.3	4.7	3.9	4.2	4.6	3.7
Infant Mortality Rate (per 1,000 live births)	6.7	7.1	6.2	6.9	7.3	6.4	6.7	7.3	6.1
Toddler Mortality Rate (per 1,000 population aged 1 – 4 years)	0.4	0.4	0.3	0.4	0.4	0.3	0.4	0.4	0.4
Under – 5 Mortality Rate (per 1,000 live births)	8.1	8.6	7.6	8.4	9.0	7.7	8.3	8.9	7.6
Maternal Mortality Ratio (per 100,000 live births)	29.1	:	29.1	23.8	:	23.8	22.3	:	22.3
Life Expectancy at Birth (in years)	74.7[p]	72.5[p]	77.2[p]	74.6	72.5	77.1	74.5	72.4	77.0
Distribution of Live Births by Birthweight (%):									
• under 2.5 kg	11.41	10.45	12.43	11.53	10.55	12.58	11.20	10.27	12.18
• 2.5 kg and over	88.45	89.40	87.43	88.31	89.28	87.27	88.62	89.55	87.63
• unknown	0.14	0.15	0.14	0.16	0.17	0.15	0.18	0.18	0.19

[a] 2014-2016: Current Population Estimates 2014 (Final), 2015 (Final) and 2016 (Estimates). The added total differ due to rounding.

[p] Preliminary data : Not applicable

Source: Department of Statistics, Malaysia

Table 3-2 Statistics Causes of Death For Male

- **The five principal causes of death for males unchanged**

Ischaemic heart diseases recorded the highest percentage of 16.0 per cent, followed by Pneumonia (11.8%), Transport accidents (6.5%), Cerebrovascular diseases (6.4%) and Malignant neoplasm of trachea, bronchus & lung (2.7%).

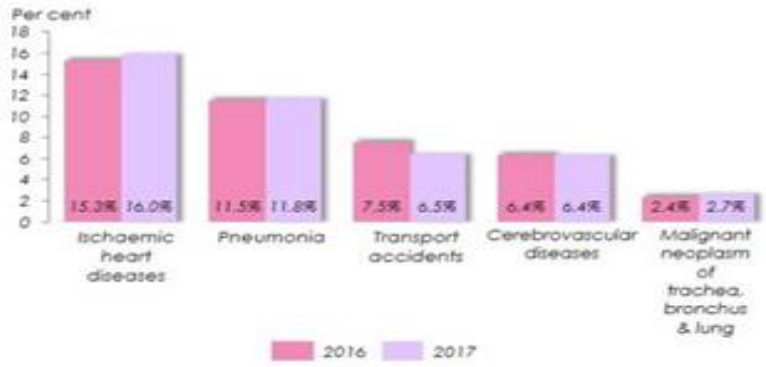


Table 3-3 Statistics Cause of Death For Female

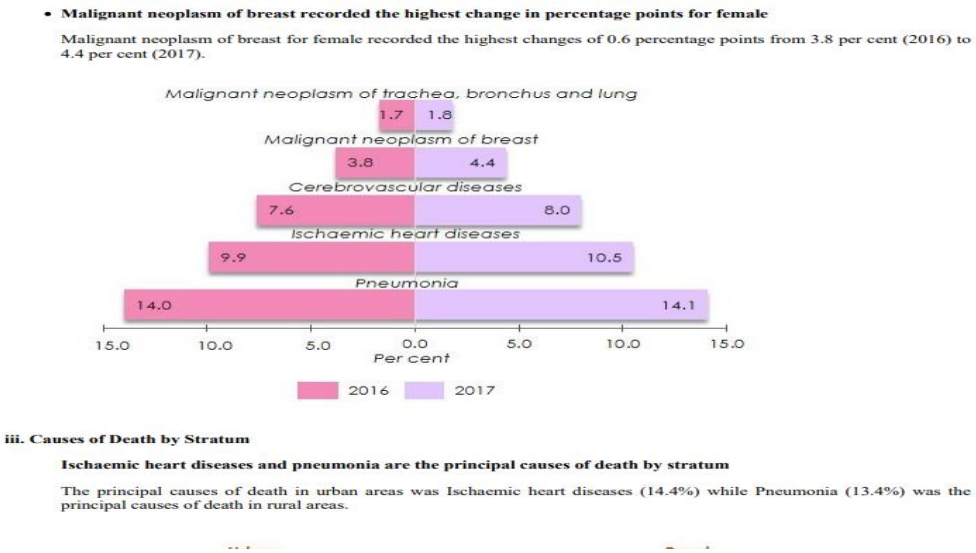


Table 3-3 Shows About Percentage of Pneumonia That Recorded by Female as The Highest Diseases Caused Death

4. Healthcare System in Malaysia (Organization and Governance)

The Malaysian healthcare system was governed under threegroups, which means three types of ownership distinguish hospitals in Malaysia such as government public hospitals, privately owned hospitals and non-profit private hospitals (Rasiah,R, Abdullah, R, &Tumin, M, 2011). In addition to, the Malaysian health care system consists of tax-funded and full government-run universal services and fast-growing private sector. Generally, public-sector health services are organized under a civil structure and centrally administered by the Ministry of Health (MOH). Other than that, Ministry of Health also regulates about the pharmaceutical industry and food safety. Meanwhile, private sector tax-funded, ownership funded, self-paying fee and also through third-party paying like as health insurance.

Public sector (MOH) provides comprehensive range of services such as health promotion, disease prevention, curative and rehabilitative care delivered through clinics and hospitals.

The private health sector provides health services that focus on urban areas, through physician clinics and private hospitals with special treatment for curative care. The table above address on contribution of the public sector and private sectors in healthcare system.

Table 4-1 Public Health Sectors

Healthcare Facilities, 2016 (as of 31 December)

Government

• Ministry of Health	NO.	OFFICIAL BEDS
Hospitals and Special Medical Institutions	144	41,995
- Hospitals	135	37,293
- Special Medical Institutions[1]	9	4,702

	NO.	TEAMS
Health Clinics		
- Health Clinics[2]	1,060	-
- Community Clinics (Klinik Desa)	1,803	-
- Mobile Health Clinics (Teams)	-	204
- Flying Doctor Services (Teams)	6 (Helicopters)	12

[1] refers to Rehabilitation Hospital (1), Women & Children Hospital (1), National Leprosy Control Centre (1), Institute of Respiratory Medicine (1), National Cancer Institute (1) and Psychiatric Institutions (4)

[2] Health Clinics include Maternal & Child Health Clinics

Healthcare Facilities, 2016 (as of 31 December)

Government (contd.)

• Ministry of Health	NO.	DENTAL CHAIRS
Dental Clinics		
- Standalone Dental Clinics	56	503
- Dental Clinics in Health Clinics[1]	587	1,486
- Dental Clinics in Hospitals	67	376
- Dental Clinics in Other Institutes	19	18
- School Dental Clinics[2]	925	813
- Mobile Dental Clinics[2]	35	55
Dental Mobile Teams		
- Pre-School	136	
- Primary & Secondary School	446	2,739[a]
- Elderly/Special Children	4	

[1] Includes Dental Clinics in Maternal & Child Health Clinics

[2] Includes Dental Clinics in primary and secondary school

[a] Refers to portable dental chairs.

Healthcare Facilities, 2016 (as of 31 December)

Government (contd.)

• 1Malaysia Clinics	NO.	TEAMS
- 1Malaysia Clinics	357	-
- 1Malaysia Mobile Clinics (Bus)	7	12
- 1Malaysia Mobile Clinics (Boat)	4	8

	NO.	DENTAL CHAIRS
- 1Malaysia Dental Clinics (UTC)	18	34
- 1Malaysia Dental Clinics (RTC)	3	4
- 1Malaysia Mobile Dental Clinics (Bus)	1	1[a]
- 1Malaysia Mobile Dental Clinics (Boat)	2	0[a]

• Non Ministry of Health	NO.	OFFICIAL BEDS
Hospitals[b]	9	3,683

Table 4-2 Private health sectors

Healthcare Facilities, 2016 (as of 31 December)

Private

• Licensed	NO.	OFFICIAL BEDS
Hospitals	187	13,957
Maternity Homes	10	30
Nursing Homes	17	615
Hospice	2	17
Ambulatory Care Centre	73	131
Blood Bank	4	25[1]
Haemodialysis Centre	423	4,529[2]
Community Mental Health Center	1	-
Combined Facilities[3]	2	73/29[2]
• Registered		
Medical Clinics	7,335	-
Dental Clinics	1,992	-

1 *Refers to Banks/Tanks*
2 *Refers to dialysis chairs*
3 *Combination of Ambulatory Care and Haemodialysis Centre*
Source: Medical Practice Division, MoH

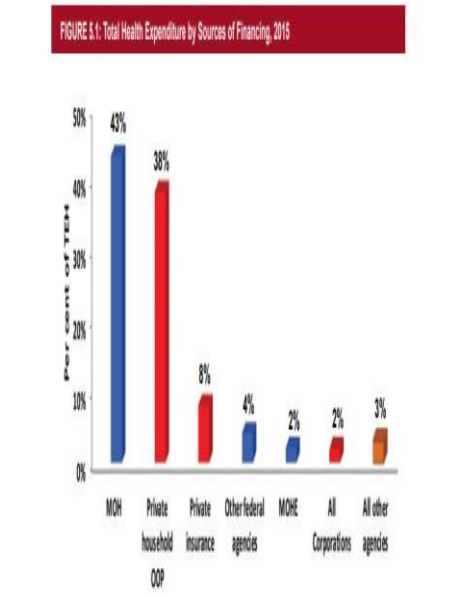
Moreover, nongovernment organizations also provide some health services for particular groups such as Chinese and Malay. These groups are usually finding services for traditional medicine which be a choice for them in getting a healthy lifestyle.

5. Healthcare Expenditure

Health expenditure became more important for the Malaysia budget in 2018. Spending on healthcare (at 4.6 GDPs in 2016) remains below the average for upper-middle-income countries. Generally, the health system in Malaysia is financed thoroughly general revenue and taxation collected by the federal

government, while the private sector is funded through private health insurance and out-of-pocket payments from consumers. Sources for financing in healthcare expenditure comes from multiple public and private sector agencies. Among public-sector sources of financing are the federal government, state government, local authorities, and social security funds. At the same time, for private-sector sources of financing comes from private insurance enterprises, managed care organizations, private household OOP, non-profit institutions, and private corporations (*Malaysia National Health Records, 1997-2015*). In 2015, the Ministry of Health had the highest expenditure to RM 22,673 million (5,535,868 USD) or 43 percent share of total healthcare expenditure. This followed by private household Out-of-Pocket (OOP) spending of RM 19,852 million or 38 percent share of total expenditure.

Table 5-1 Total Health Expenditure by Sources of Financing, 2015



MNHA code	Sources of Financing	RM Million	Per cent
MS1.1.1.1	Ministry of Health (MOH)	22,673	43.10
MS2.4	Private household out-of-pocket expenditures (OOP)	19,852	37.73
MS2.2	Private insurance enterprises (other than social insurance)	4,050	7.70
MS1.1.1.9	Other federal agencies (including statutory bodies)	2,249	4.28
MS1.1.1.2	Ministry of Higher Education (MOHE)	1,207	2.30
MS2.6	All Corporations (other than health insurance)	1,148	2.18
MS2.3	Private MCOs and other similar entities	378	0.72
MS1.2.2	Social Security Organization (SOCSO)	261	0.50
MS1.1.2.2	Other state agencies (including statutory bodies)	196	0.37
MS1.1.3	Local Authorities	178	0.34
MS1.1.1.3	Ministry of Defence (MOD)	169	0.32
MS2.5	Non-profit organisations serving households (NGO)	98	0.19
MS1.1.2.1	(General) State Government	92	0.17
MS1.2.1	Employee Provident Funds (EPF)	52	0.10
MS9	Rest of the world	5	0.01
Total		52,609	100.00

Refer to the table above, after MOH and OOP, the next higher spending is private insurance which is 8 percent, other federal agencies which is 4 percent and followed by the Ministry of Education (MOHE). Then remaining sources is 2 percent of the total healthcare expenditure. Besides, the table below shows about total expenditure on healthcare financing by public and private sector.

Table 5-2 Total Health Expenditure by Sources of Financing (Public vs. Private), 1997-2015

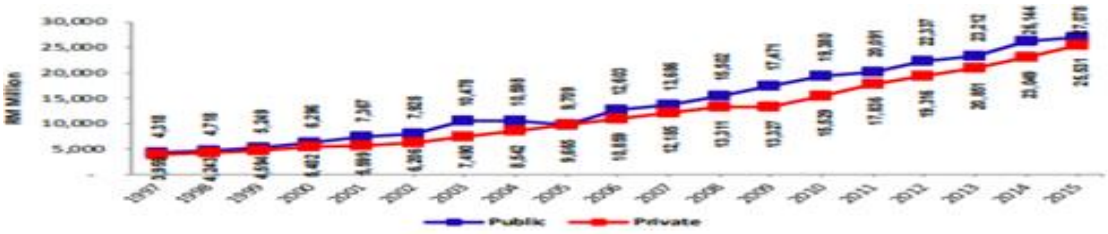


TABLE 5.2: Total Expenditure on Health by Sources of financing by Public & Private Sectors, 1997-2015

Year	Public		Private		Total
	RM Million	%	RM Million	%	RM Million
1997	4,318	52.17	3,959	47.83	8,277
1998	4,718	52.65	4,243	47.35	8,961
1999	5,249	53.33	4,594	46.67	9,843
2000	6,296	53.82	5,402	46.18	11,698
2001	7,367	56.82	5,599	43.18	12,966
2002	7,928	56.09	6,206	43.91	14,134
2003	10,478	58.31	7,490	41.69	17,969
2004	10,598	55.37	8,542	44.63	19,140
2005	9,709	50.11	9,665	49.89	19,374
2006	12,603	53.72	10,859	46.28	23,462
2007	13,686	52.90	12,185	47.10	25,870
2008	15,502	53.80	13,311	46.20	28,813
2009	17,471	56.73	13,327	43.27	30,798
2010	19,380	55.52	15,529	44.48	34,909
2011	20,091	52.97	17,836	47.03	37,927
2012	22,337	53.63	19,316	46.37	41,652
2013	23,212	52.68	20,851	47.32	44,063
2014	26,144	53.15	23,049	46.85	49,193
2015	27,078	51.47	25,531	48.53	52,609

This table starts by comparing the health spending of the public and private sector. In the 2015 year, the public and private spending are 6,610 million in USD and 6,232 million in USD. During this period, both public and private sector spending shows an upward trend with the public sector share the highest contribution in healthcare sector.

5.1 Ministry of Health (MOH)

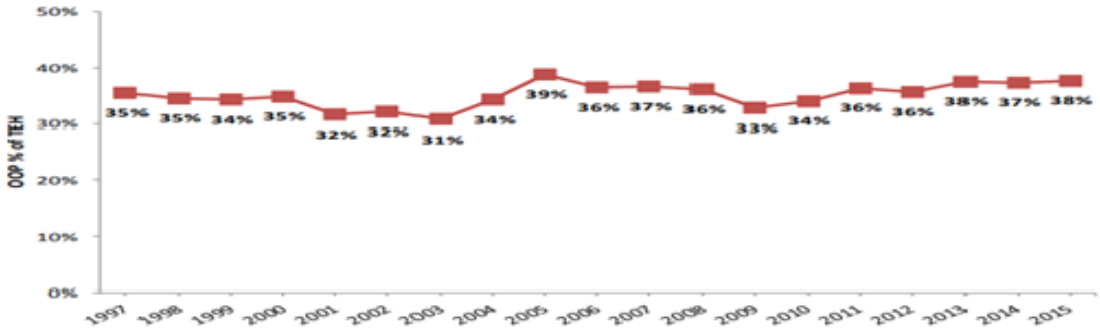
In Malaysia, MOH dominating all the healthcare expenditure in giving the best services for the citizens, which ranges between 40-49 percent. The allocation is used in health-related services provided by hospitals, clinics, public health labs, research training, and others. Besides, MOH put allocation for purchasing outsources services such as hospital maintenance.

5.1-1 Ministry of Health (MOH) Recurrent and Development Allocation, 1997-2015

5.2 Out-of-Pocket Health Expenditure

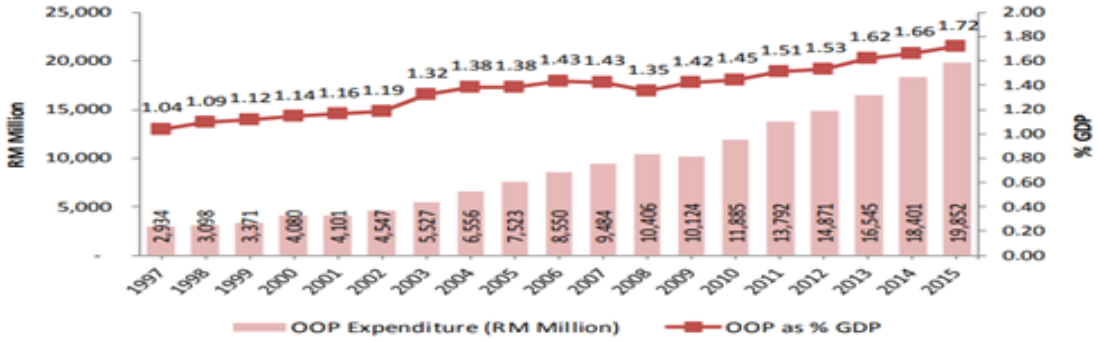
Out-of-pocket (OOP) payments are the primary means of financing health care throughout all country in Asia include Malaysia. In 1997-2015, time series data shows that the household Out-of-pocket health expenditure is the largest source of funding in the private sector which 38 percent from total of healthcare expenditure.

Table 5.2-1 OOP Share of Total Health Expenditure, 1997-2015 (percent, %)



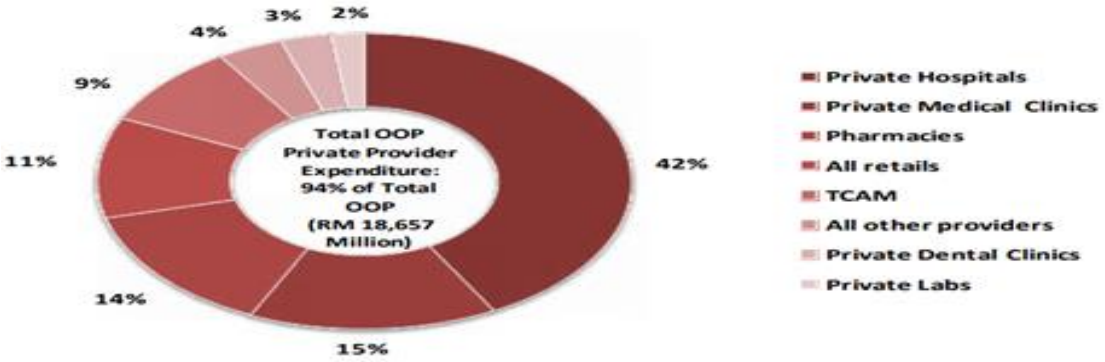
The 1997- 2015 timeline shows that the private sector still spends which is equivalent to about 30-40 percent of total healthcare expenditure. Regarding the table, usually, people with medical coverage was provided through the government, employers or private insurance funds were better to use private health care and had higher household expenditure.

Table 5.2-2 OOP Health Expenditure and percent GDP, 1997-2015 (RM Million, Percent %)



In Malaysia, private healthcare expansion began during Mahathir Mohamed era, in which he also becomes two times Prime Minister and now he is our seventh Prime Minister of Malaysia. For high demand for the getting excellent, faster and quality in healthcare services, most of the people or patients seek treatment in private sector, in which they are often liberty to buy these services or products separately and the patient had the freedom to choose in what they want to get services. The private sector provides several categories of private facilities such as private hospital, private medical clinics, providers of medical appliances, traditional, and complementary care providers, private dental clinic, private pharmacies and private laboratories.

Table 5.2-3 OOP Health Expenditure by Functions of Health Services, 2015 (percent, %)

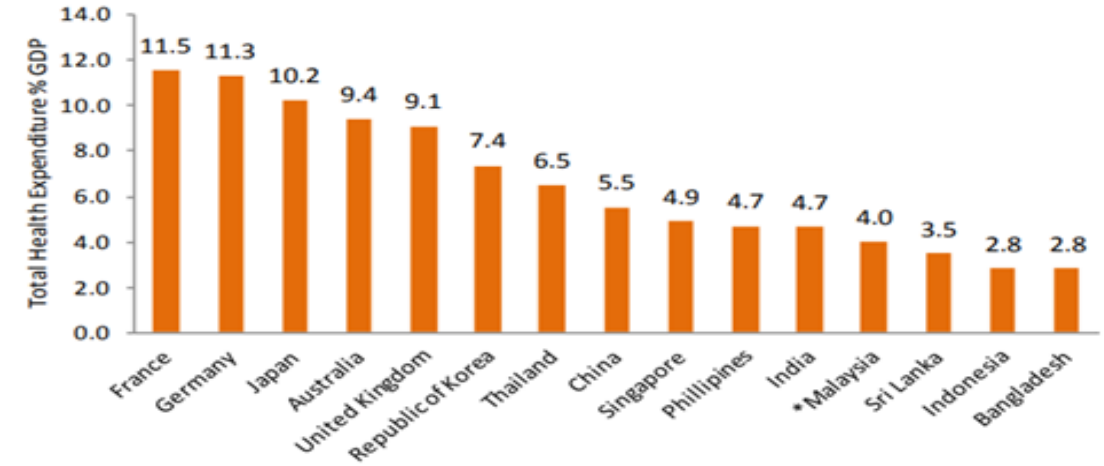


The table above shows the contribution of private sector in healthcare services. So, the most contribution in healthcare expenditure is from Private Hospital which is 42 percent, then private medical clinics are 15 percent, then pharmacies are 14 percent and the other remains is 29 percent. Thus, from 1997 till 2015, time series data shows private sectors are very crucial because of getting a lot of contributionsto healthcare expenditure.

6. International Comparison

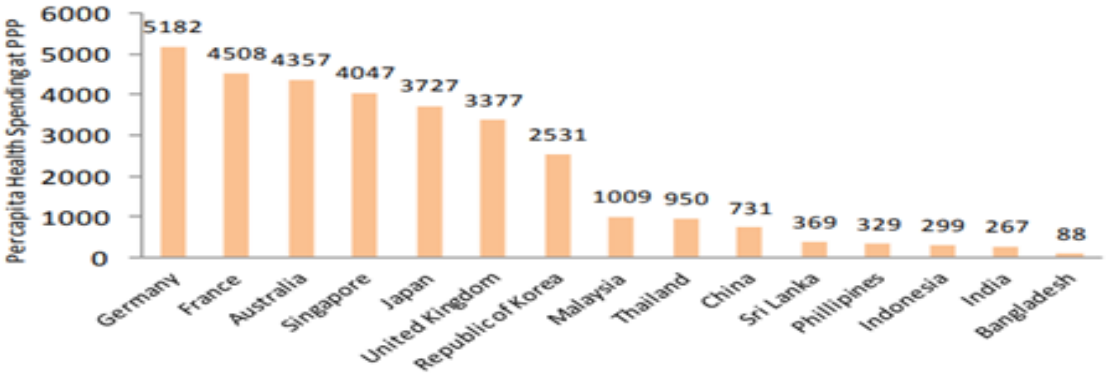
Policy makers also make a comparison with other countries in making a big decision. Thus, in order to get cooperation among these countries, World Health Organization (WHO) will convinceall these countries to use System Health of Accounts (SHA)for standardizing and analysing healthcare expenditure data that comparable and reliable international health expenditure data. However, Malaysia also produces health expenditure data based on Malaysia National Health Accounts (MNHA) and SHA, butGlobal Health Expenditure Database (GHED) had been used in order to get standardize data in the same year. In this section, comparison on healthcare expenditure made that consist 3 European countries (France, Germany, and United Kingdom), seven countries in Asia (Sri Lanka, India, Bangladesh, China, Japan, Republic of Korea and Philippines), three countries neighbouring Malaysia (Singapore, Indonesia and Thailand) and Australia. Based on GHED database, health spending in Malaysia is 4.2 percent of GDP (Table 6-1). India, Philippines, Singapore, China, Thailand, and the Republic of Korea spent more than Malaysia but lower than European countries such as France, Germany, United Kingdom and Australia which they spent more than 9 percent GDP.

Table 6-1 International Comparison of Total Health Expenditure as Percent GDP, 2014



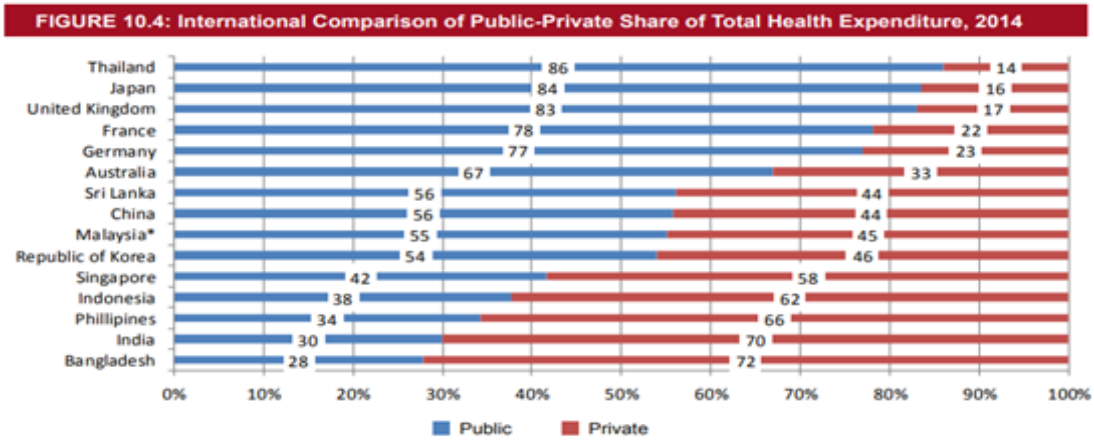
Source: Global Health Expenditure Database (GHED) WHO NHA on 31st July 2017

Table 6-2 International Comparison of Per Capita Health Expenditure at PPP, 2014 (USD)



Source: Global Health Expenditure Database (GHED) WHO NHA on 31st July 2017

Table 6-3 International Comparison of Public-Private Share of Total Health Expenditure, 2014



Source: Global Health Expenditure Database (GHED) WHO NHA on 31st July 2017

However, the regional countries like Thailand, Philippines, India, Bangladesh similar to Malaysia GDP spending, in which they have much lower per capita spending ranging from USD 88 in Bangladesh to USD 950 in Thailand. However, the regional countries like Thailand, Philippines, India, and Bangladesh with similar to Malaysia GDP spending has a much lower per capita spending ranging from USD 88 in Bangladesh to USD 950 in Thailand compared to Malaysia spending USD 1,009 (Table 6-2). Thus, it

can conclude that the population of a country affects the per capita spending value as countries with a large population.

Discussion and Conclusion

Malaysia offers impressive health gains for its population with a low-cost health care system that provides universal and comprehensive services by funding through general revenue. Based on this article, Malaysia has formed a much-admired model in terms of the public sector and the private sector that implements lots of alternatives to delivering excellent health services to the population. Besides, in Malaysia the healthcare system 75% from the public sector and highly subsidized by the public sector, thus residents can enjoy getting health services and ought good financial risk protection from ill health.

Nevertheless, there are challenges that will arise in the future. First of all, the equity challenges are that growth of out-of-pocket payments, in which its affect fundamental of Malaysia's healthcare principle address for the access of quality healthcare, residents not should depend on the ability to pay. Then, as Malaysia approaches developed nation status, and as technology become expands, the possibilities for intervention and demand for health care by population continue to rise. Pressures are continually rising up for health reform in Malaysia looking towards the year 2020 and beyond.

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THE ROLE OF ORGANIZATIONAL CYNICISM FOR THE EFFECT OF EMOTIONAL LABOR ON INDIVIDUAL WORK PERFORMANCE

Emre İŞÇİ[1]
Marmara University
Hüseyin ARI[2]
İstanbul Arel University

Abstract

This study's aim was to investigate the role of organizational cynicism for the effect of emotional labor on individual work performance. The research, which was planned in order to produce more explanatory results in terms of organizational behavior for managers in health sector. This study was conducted A, B, C type classified private hospitals of İstanbul. The sample of this research consists of 390 nurses who can contact face to face with patients per 130 for each class.

According to results of this research, it could not detect any relation between emotional labor and individual work performance statistically. Yet, there is poor negative relation (p=0,01, r= -0,144) between surface acting and individual work performance. In addition, there is poor positive relation (p=0,05, r= 0,100) between deep acting and individual work performance. The cause of relevant poor relations is that nurses consider themselves competent in the context of individual work performance (4.05 ± 0.77).

Contrary to the expectations, research results indicated that nurses' level in both emotional labor and organizational cynicism were low. The cause why organizational cynicism average (2.45 ± 0.91) was low than expectation, as suitable with literature results, is that health care workers cover up their cynic attitudes in order to not losing their status and income. Emotional labor's average lowness than expected was interpreted as that workers did not internalize the nature of performing job or not including the motivators which work conditions pushing them to display emotional labor.

As a result, this study suggests increasing worker's emotional labor values by keeping them in organizations for long term and in addition, enabling workers to speak about process that affects them directly.

Keywords

Emotional labor, Organizational Cynicism, Individual Work Performance

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[1] Department of Health Management, Health Sciences Faculty, Marmara University, emreisci@yahoo.com

[2] Correspondence to: Health Institutions Administration Programme,Vocational School, İstanbul Arel University, huseyinari@gmail.com

Introduction

1. Emotional Labor

Labor is defined the activity of generating the means of supports (Kazgan, 2012). In this regard, labor is a factor of production. However, human production does not just represent endeavoring. From this respect, the most dissimilatory feature of humankind from other living being is that humankind can plan and protect the product process legally (Braverman, 1974). Otherwise, it would be impossible to distinguish humankind efforts from animals. In this regard, humankind have free will on supplying of their labor.

It is known that service sector's volume is so important in context of economic magnitude of developed and developing countries and their developmental level. Although intelligent technology and software, which are in order to eliminate faults, supersede the production based human endeavoring, the dynamic of service sector, which based human endeavoring, sustains its effect still.

Intangible, heterogeneous, simultaneous production-consume features of services give humankind's talent, ability and performance prominence in service sector (Parasuraman et all., 1985). At the same time, personals in service organization have to contact with people that they provide service. In this respect, it is thought that one of the factors that contribute the production of both workers and organizations is emotional labor. Likewise, reciprocal emotional interaction comes about during this communication. This interaction has a big importance that have role on evaluation of enterprises. Because of this condition, it is demanded from workers to be addressed to emotions of customers as part of their job (Rafaeli and Sutton, 1987). From this respect, it is seen that emotions have economical value and they can be exchanged for a fee although they are abstract (Hochschild, 1983).

Emotional labor is a structure that includes suppressing, enforcing and faking it in order to regulate emotional expressions (Grandey, 2000). Emotional labor is also stated as a reflection of emotions and feelings that are needed to collaboration with customer and co-workers, as ability to integrate it with organizational perspective (Meier et all., 2006; Sheih, 2011). In other words, emotional labor is explained as displaying suitable emotional reactions (Ashforth and Humphrey, 1993). Generally, emotional labor is a process of managing feelings and emotions that are expected from workers in compliance with norms decided by organization (Wharton, 2009). If emotional labor is examined as an inward process, it can be said that emotional labor is managing of workers' emotion by striving in case of interaction with others in workplace. In the light of these definitions and approaches to concept of emotional labor, some features of emotional labor can be viewed at figure 1.

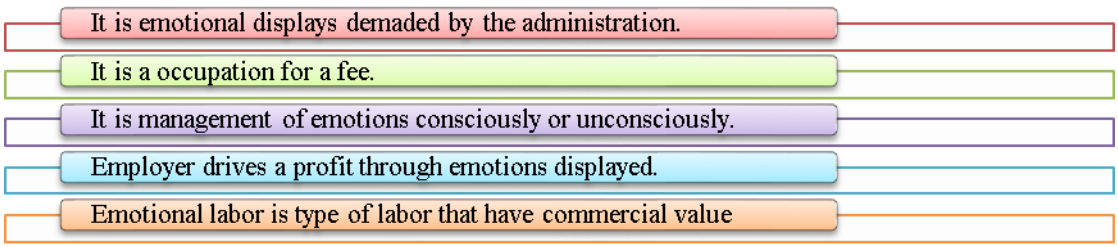

Figure 1: Covalent Elements of Emotional Labor

Resource: Grandey et all., 2013; Hochschild, 1983; Delen, 2017

When examined the concept of emotional labor it is seen that there are its three dimensions as surface acting, deep acting and natural acting. Surface acting is explained with the concept of false self. With reference to it, false self is a defensive behavior that ensures to be gained recognition by concealing true self in order to cover up the empathy failure due to the demand of social environment (Winnicott, 1965). In this regard, emotional expressions are reinvented and controlled in surface acting. While attending to tough customer or while in bad emotional situation, artificial smiling is an example of surface acting (Brotheridge and Grandey, 2002; Ashforth and Humprey, 1993). In this respect, surface acting means is no sincere, but is having an attitude that is far from internalizing. Surface acting which are displayed outwardly is impressionistic phenomenon reflected to other side (Grandey, 2000).

Surface acting which are displayed in the way of not representing yourself can convert to deep acting in the way of playing role of one's psychology of portrayed character (Hochschild, 1983). Worker shows empathy and struggles to act deep acting by perceiving the costumer's emotional situation (Rupp et all., 2008). In this regard, emotional labor have to be viewed as psychological process that workers must regulate their emotional situation by empathize with those who they service (Grandey, 2000).

It have been alleged that one of emotional labor type is also natural acting. It realizes in the way of sympathizing to ones who workers service without any empathy. Said sympathy does not require any role and changing of the self. Emotional concern or humane sentiment of one nurse to crippled child is example for natural acting (Astforth and Humprey, 1993). This emotional reflex, which is sincere, can be also expected by other side. This type of emotional labor is also named as passive deep acting because there is no any manipulation to other side (Prati, 2004).

2. Individual Work Performance

Imperative working conditions like unemployment, low of wages, obligation of working in shift, which economic competition cause, increase the pressure on the worker for increasing individual work performance nowadays (Carneiro ve Novais, 2017). There is no any approach agreed on what individual work performance is. For example, while productivity is important for management sciences; adaptation, satisfaction and selfness come to the forth for organizational psychology (Beaton et all, 2009; Barrick et all.,2001). From this respect, some discussions on whether individual work performance definitions are focused on output or behavioral took place. Therefore, the necessity of differentiate individual work performance from labor productivity came off (Koopmans et all., 2011). In this regard, individual work performance is viewed as suitable set of behaviors for general organizational goals (Murphy and Kroeker, 1988).

According to this approach, there are three essential feature of individual work performance (Koopman et all., 2011):

1. It is a notion related to behaviors than output
2. It encompasses behaviors related to organizational goals
3. It includes a multidimensional structure

Individual work performance is investigated under four top title. These have been depicted at figure 2 (Koopman et all., 2011; Viswesvaran and Ones, 2000)

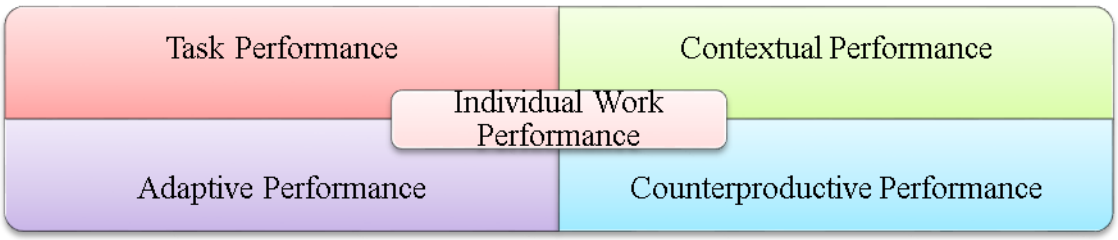

Figure 2: The Dimensions of Individual Work Performance

2.1. Task Performance

Task performance is the first individual work performance coming to mind probably. There are a lot of explanation and describing for task performance in academic literature. However, common point of these is that vocational talent and abilities come to forth in scope of task performance (Bağcı, 2014; Greenslade and Jimmieson, 2007).

Task performance encompasses a lot of mission and duties depended on job (Jawahar and Carr, 2006). In other words, task performance includes essential responsibilities customized the occupation professed that is determined by experience and technical ability (Conway, 1999). In this respect, task performance is defined as individual work performance indicator that contributes to production techs of organization directly (Motowidlo et all., 1997).

Task performance are also separated as routine and creative task performance (Brüggen et all., 2017). While routine task performance means fulfilling work process designated excellently, creative task performance means generating the result demanded by discovering unexperienced methods (Jäder et all., 2017). The need of creative task performance rises because many works got routine due to technological development (Acemoğlu and Autor, 2011). From this point, industries in service sector that product based on knowledge (for example hospitals) have to employ the workers who take in charge of creative duties based on discrete and analytic ability (Acemoğlu and Autor, 2011; Fonseca et all., 2018).

Attitudes and behaviors composing task performance can vary according job or vocation professed as expressed before. Five fundamental individual work performance within task performance for nursing have been ranked as following (Greenslade and Jimmieson, 2007).

Planning patient care,

Fulfilling the demands of patients related to disease and monitoring medical variables,

Informing about health situation and the process of treatment to patients and their relatives,

Providing emotional support for anxious and fears of patients and their relatives,

Co-coordinating with other medical departments for treatment and caring.

2.2. Contextual Performance

Contextual performance can be defined as set of behaviors that include willingness for fulfilling task activities and cooperation with other workers in organization in order to achieve (Borman and Motowidlo, 1997). According to this approach that individual work performance does not consist of task performance, *interpersonal relationship* (Murphy and Kroeker, 1988; Wisecarver et all., 2007), *extra-role performance* for customers and organization (Maxham et all., 2008), *organizational citizenship* (Organ, 1997; Viswesvaran, 1993) and *prosocial behaviors* beyond specifications of task performance (Katz, 1964; Viswesvaran, 1993) compose the contextual performance.

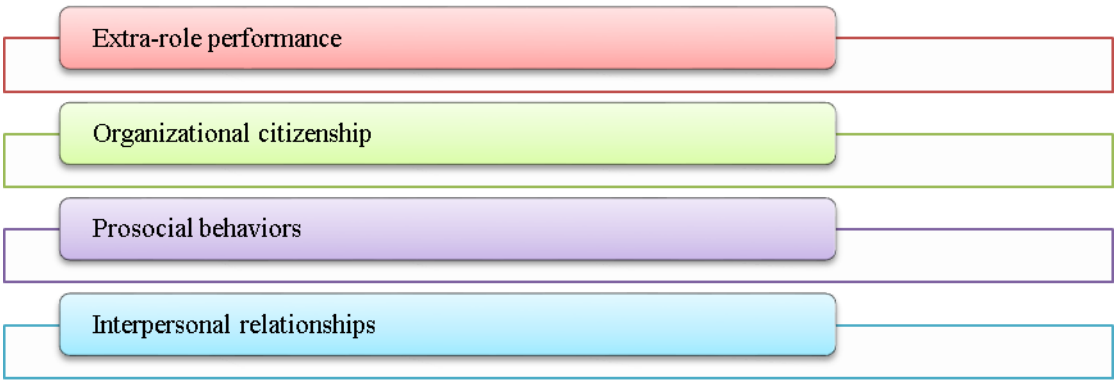

Figure 3: Contextual Performance Labels

If examined heedfully, it is seen that extra-role performance means general a term composed in that way of including organizational citizenship, prosocial behaviors and interpersonal relationship behaviors. For example organizational citizenship behaviors is viewed in context of extra-role performance (Zhu, 2013; Hsu et all., 2017).

Interpersonal relationship generally defines the ability to set up good communication with other side (*co-workers, manager*) (Murphy and Kroeker, 1988). In this regard, it is necessary to set up good communication and collaboration with stakeholder interacted while fulfilling tasks responsibilities. Otherwise, poor interpersonal relationship also decrease general job performance (Murphy and Kroeker, 1988).

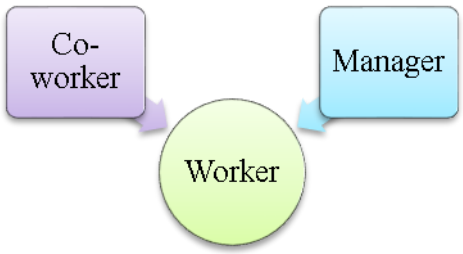

Figure 4: The Way of Interpersonal Relationship

Source: It was adapted from publication of (Murphy and Kroeker, 1988)

Attitudes and behaviors composing interpersonal relationship is a fact experienced subjectively; namely impressively conveyed to other side, and they are explained as a continuous interaction aspect (Reich and Hershcovis, 2011). Interpersonal relationships in work life is referred as a compound of

psycho-social work conditions that are motivated by personality characteristics (Stoetzer, 2010). Set of probable attitudes and behaviors of a workers in context of inter or multi relations in organizations was depicted at figure 5 (https://www.adams.edu/administration/hr/performance%20review.pdf, Accessed Date: 23.04. 2018):

Figure 5: Type of Interpersonal Relationship Behaviors

Interpersonal relationship need to contribute to achievement in production process to view as a performance criterion. For example, while taking care of customers, sincerity and respect of the worker towards them or her/his the ability to communication and collaboration would reach significant providing that they are satisfied. However, although customer satisfaction cannot be got in spite of these behaviors, they even so should consider as criterion of contextual performance because theirs aim is to reach it. As referred before, individual work performance is a notion related to behaviors than output (Koopman et all., 2011).

One of essential indicator of interpersonal relationship is workers' disposition to collaboration. It is asserted that the collaboration with both co-workers and their managers facilitate to reach organizational goals (Schalk and Curşeu, 2010). In order to define a behavior as collaboration, working together and an agent for a general aim require (Chen et all., 1998; Schalk and Curşeu, 2010).

One of the situations where cooperation behavior is important is that situations that working with subordinate personnel for the benefit of third party is compulsory. For example, detecting the cause of any fault committed to customer entails this kind of collaboration. Otherwise, most penalty would paid by the organization by means of being damaged corporate reputation. In this regard, the consent of worker to be directed by his manager can consider as other positive interpersonal relationship performance.

Organizational citizenship is defined a concept that are displayed independently of organizational reward mechanism, namely discretionally (Organ, 1988; Ahmad and Saud, 2016), that includes the approach of giving someone a helping hand by going beyond fundamental job requirement (Zhang, 2011).

Organizational citizenship, which is also considered set of behaviors that increases profitability over the long term (Zhang, 2011), was associated as a part of contextual performance in the way of the approach of being altruistic (Organ, 1997). It is considered that organizational citizenship behaviors or attitudes is associated as conscientiousness, being altruistic, being kind, being virtuous and being gentleman (Singh and Singh, 2008).

Figure 6: Types of Citizenship Behaviors

Source: It was adapted from publication of (Singh and Singh, 2008)

Conscientiousness requires to obey the organizational rules or to participate organizational formations; being altruistic requires to help without expecting a response; being kind requires to consult to others before making decisions even though it is unnecessary; being virtuous requires to get over problems affecting to organization and lastly being gentleman requires to avoid from gossips and rumors or requires to not exaggerate petty issues (Singh and Singh, 2008).

Prosocial behaviors, which are exemplified as helping, sharing, endowing, collaboration and willingness, refers to behaviors like the integration with organization, taking action to provide the organization from hazardous situation, speaking out positive things towards third parts, readiness for more important occupations that requires high responsibility and making suggestion for organizational development lastly (Brief and Motowidlo, 1986).

Said prosocial behaviors that are displayed discretionally (Viswesvaran, 1993) was shown at following figure (Brief and Motowidlo, 1986).

Figure 7: Types of Prosocial Behaviors

Intervening, making suggestions and direction in order to remove the blockage in production process are most common prosocial behaviors in context of helping co-workers. Handling some business of co-worker who is late for job, taking responsibility of co-workers who cannot complete their business because working equipment was broken down, being on night duty in hospital for his/her co-worker who cannot work due to personal causes can asserted as some examples of prosocial behavior in scope of contextual performance.

2.3. Adaptive Performance

Adaptive performance is defined as ability to change workers' behaviors in order to meet demands of changing environment conditions in context of individual work performance (Charbonnier-Voirin and Roussel, 2012). According to other approach, adaptive performance is a notion that have its cognitive and emotional dimensions, which include a disposition to change job requirements, unlike task performance (Allworth and Hesketh, 1999). However, it is considered that adaptive performance affects task performance positively (Shoss et all., 2012).

Many environmental factors like technological change, knowledge-based production, competition due to globalization and the need of controlling costs cause to arise the adaptive performance that needs customizing of workers in terms of consideration, value and behavior (Ployhart and Bliese, 2006). Adaptation areas for future economic system was shown at Figure 8 (Ployhart and Bliese, 2006).

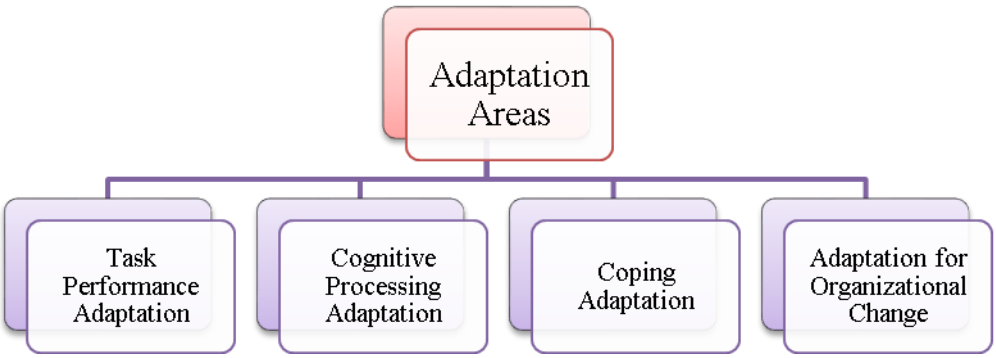

Figure 8: Adaptation Areas in Context of Individual Work

Task performance adaptation refers to attuning of worker in context of talent, ability and knowledge in order to respond environmental change (Ployhart and Bliese, 2006). For example, while it was expected from secretaries to use typewriter before 60 years, it is now expected from them to use computer and software technologies perfectly. In this regard, secretaries who can convey their ability and knowledge to software technologies have stayed on their task. Others have lost their jobs.

Cognitive processing adaptation is referred as ability to choose suitable alternatives correctly by catching marks of changing (Ployhart and Bliese, 2006). Specially, it can be considered this kind of adaptation is more important for manager staff. Applying "A" or "B" plans responsively or specifying proper plan of them should consider as fundamental feature of cognitive processing adaptation.

Copying adaptation is explained as ability to work out in case of one of stress factor (Ployhart and Bliese, 2006). For example, in case of occurring a problem, flexibility to solve fast can be considered as an ability that workers should have in operational level. In this respect, it is necessary to be known of alternatives that fulfill the task.

Adaption for organizational change can be referred as positive reactions in terms of emotional, cognitive, communication and being included of decisions to organizational change carried out to take competitive edge (Witting, 2012). For example, changing of production process, of technology used and of current norms can cause to organizational change. In this regard, low resistance to organizational change and integration of workers to this change should consider as an important adaptive performance in terms of individual work performance.

As long as environment conditions change continuously, importance of adaptive performance comes to forth. In this respect, organizations in this conditions need to organic organization structure that qualifications of workers are more valuable and formality level is low (Koçel, 2011). Specific adaptive performance behaviors or attitudes are shown at figure 9 (Pulakos et all., 2000).

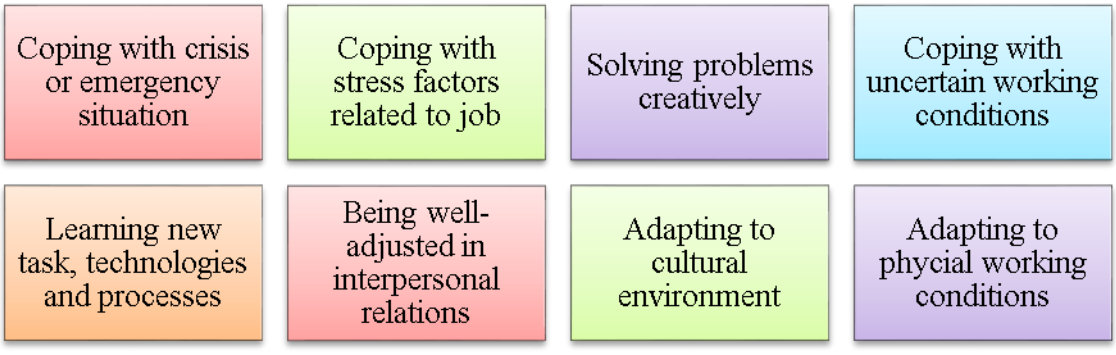

Figure 9: Adaptive Performance Behaviors & Attitudes

Coping with crisis or emergency that can endanger the life is vital for healthcare organizations. For example, in case of fire in hospital, it is expected from workers to control their emotional situation and to take action (Pulakos et all., 2000).

Coping with stress that occurs depend on workload, participation and control, working hours and job content (Leka et all., 2004) is other type of adaptive performance. Having not enough time to complete a project is an example of stressor factors (Pulakos et all., 2002). In this conditions, not blaming of others as source of problem or taking action to accelerate process should be considered expected adaptive performance behaviors (Pulakos et all., 2000; Marques-Quinteiro et all., 2015).

Solving problem creatively is referred as resolving problems that cannot be found easily a remedy (Pulakos et all., 2002). In order to perform it, it is necessary to be creative of workers, to analyze opportunities for solving and to increase quality of production in terms of them (Pulakos et all., 2000; Pukalos et all., 2002). Being created excel calculation table by a personnel in discharge department of hospital in order to accelerate discharge of patient, in terms of health insurance process, should be considered as adaptive performance example.

Coping with uncertain working conditions is also other indicator of adaptive performance. It is expected from worker to react for sudden developments in this individual performance type (Pulakos et all., 2000). Opening new room for an inpatient by night supervisor of hospital by changing hospitalization plan of next day can be asserted as other adaptive performance example.

One of the adaptive performance is learning new task, technologies or processes (Pulakos et all. 2002). It is not possible to work in the same job with same knowledge or ability in the contemporary world where types of working is changing all the time. It can asserted that learning new task, technologies or processes is most demanded performance type from workers by their managers in case of high staff turnover. Most important obstacle in this case is to employ new workers into any department that they did not work before because they do not accept new tasks. Therefore, it should be considered that taking responsibility on accepting new task, which is crucial for organizational interests, is most appreciated adaptive performance.

Being well-adjusted in interpersonal relations is adaptive performance indicator that requires to listen and to be open-minded while dealing with any customer (Pulakos et all., 2000). Compliance in interpersonal relations also requires catching priorities of other side and making cognitive, emotional or behavioral change in this direction (Pulakos et all., 2000; Pulakos et all., 2002). Being changed alternatives by a sales representative who perceive expectations of customer can be this kind of adaptive performance example.

Adapting to cultural environment is similar with being well-adjusted in interpersonal relations. From this context, being adapted of cultural components like symbol, language, nation, custom, religion and values of other side by workers is expected (Pulakos et all., 2000; Pulakos et all., 2002).

Workers should be more careful while communicating with the patient who have different religion or nationality and should avoid words or behaviors that may cause to conflict. Specially, some situations, which requires different approaches towards patients from nutrition to transfusion depend on their religion, might happens in health organizations. In this regard, that workers respect to changes in service process would be appropriate adaptive performance. Both being well-adjusted in interpersonal relations and adapting to cultural environment depend on social intelligence of workers (Pulakos et all., 2006).

Adapting to physical working conditions includes adjusting to physical environmental conditions like cold, heat, moisture, dryness or to physical specialties like weight, length or muscle force (Pulakos et all., 2000; Pukalos et all., 2002). For example, in aviation sector it is necessary to be suitable in terms of weight and length of any worker. In this respect, it can asserted that losing weight and keeping fit are adaptive performance.

2.4. Counterproductive Performance

Individual work performance is not always concept on behalf of organization benefits. This situation can comprehend when considered individual work performance as workers' behaviors and attitudes clearly. Counterproductive performance is defined as intentional behaviors of worker, which are contrary to legal interest of organization (Sackett, 2002). According to other approach, counterproductive performance is explained as protest behaviors of workers in order to demonstrate their dissatisfactions (Kelloway et all., 2010).

Counterproductive performance have been named with various labels. In this regard, *workplace aggression* as efforts by worker to damage co-workers or organization (Baron and Neuman, 1996), *organizational misbehaviors* as intentional actions that violate organizational norms (Vardi and Wiener, 1996), *protest form* as intentional behaviors of worker in order to emphasize injustice practices (Kelloway et all., 2010), *employee deviance* as voluntary behaviors that endanger the well-being of organization (Robinson and Bennett, 1995), and finally *anti-social* behaviors that is negative for organization (Robinson and O'Leary-Kelly, 1998) are some terms in order to describe counterproductive performance concept.

Workers can commit many counterproductive behavior includes proper-based (theft, vandalism etc.) or production-based (absenteeism, tardiness etc.) deviances that harm both co-workers and organization (Mikulay et all.,2001). The counterproductive work performance is associated with negative emotional attitude, with being on opposition to organization, with making trouble for co-workers and managers, with making mistakes deliberately (Koopmans et all., 2014). Some counterproductive behaviors are shown at figure 10 (Koopmans et all., 2011).

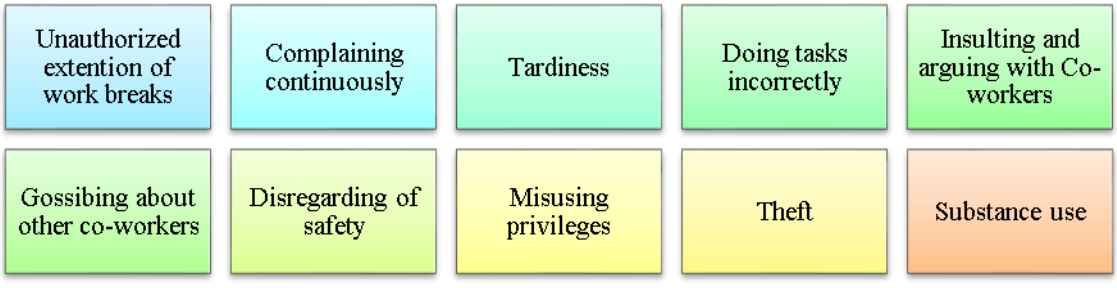

Figure 10: Types of Counterproductive Behaviors

Focus point of counterproductive individual work performance is that these behaviors are performed deliberately. Therefore, for example, a mistake committed by physician unintentionally in surgical operation does not refer to counterproductive performance (Vardi and Wiener, 1996).

3. Organizational Cynicism

3.1. Concept of Cynicism and Its Philosophical Background

Roots of cynicism have been dated back Ancient Greek Philosophy. Cynics were maintained their philosophical reviews that have virtue centered of Socrates school (Luck, 2011; Gökberk, 1993). In this intellection that is equal to have knowledge, cynics who adopted individualistic approach acknowledged avoiding pleasure and being independent from social circle as virtue (Gökberk, 1993). In this regard, there is a near connection between cynicism and stoicism (Luck, 2011).

According to Oxford English Dictionary, cynic is defined as "*one who shows a disposition to disbelieve in sincerity or goodness of human motives and actions, and is wont to express this sneers and sarcasms; a sneering fault-finder*" (Dean et all., 1998).

In other words, cynicism is a general or specific attitude characterized by frustration, hopelessness and disillusionment to any institution, to social custom, to ideology, to social group or people (Andersson and Bateman, 1997). Cynicism is also attitude of being in opposition to motivations behind actions that have skepticism querying the trueness (Turner and Valentine, 2001).

Etymologically, cynicism comes from cynic word. Cynic means "Dog" in Greek language (Luck, 2011). These people named as cynics protested all kind of idea, behavior or emotion in Ancient Greek Civilization by criticizing (Luck, 2011). These protests have been demonstrated in the way of doing the contrary because others are people who lost their virtue. In this regard, they eats if necessary and they have tendency to avoid food giving pleasure. Famous cynic Diogenes presents the standard of being virtue by saying "not needing anything is intrinsic to God, needing few thing is taking after God" (Luck, 2011).

Virtue in cynicism has a disposition to convert to asceticism (Desmond, 2008). For example, *Philon* impressed by cynicism praises asceticism and preaches to avoid any pleasure and superstition (Luck, 2011). Asceticism is rooted from Platonic life style experienced in order to achieve happiness (Dudley, 1937). In this regard, cynic asceticism has contrast with asceticism in Protestant Ethic. Thus, cynic or other ascetic approaches that are output of a sacred belief exclude the individual from daily life because special sacred life is necessary to surpass secular morals (Weber, 2017).

3.2. The Concept of Organizational Cynicism

Organizational cynicism can consider as protest movements that workers do against organization or its administration. However, this concept was defined with different emphasize points. For example, organizational cynicism as belief of not integrating oneself to organization with strong negative emotional reaction, which causes to arise depreciatory and critical behaviors (Abraham, 2000).

Organizational cynicism is also defined as a negative attitude against organization worked (Dean, 1998). According to another approach, organizational cynicism is referred as a concept that arises against unethical behaviors like unfairness, favoritism and deception (O'Leary, 2003).

3.2.1. Types of Organizational Cynicism

Concept of organizational cynicism is an umbrella term for many types of cynicism (Delken, 2004). Thus, there are five organizational cynicism dimensions.

Figure 11: Types of Organizational Cynicism

Source: Abraham, 2000; Dean, 1998; Delken, 2004

Personality cynicism is constant or inherent personal character (Abraham, 2000). These people who have lack of ability to communicate socially think that others are absolutely dishonest and selfish and do not rely on them adamantly (Abraham, 2000). These cynics think, in analogy to Marxist discourse, that they are exploited and alienated from job owing to relations of production (Guastello vd., 1992).

Social cynicism is also one of the five fundamental axiom (Bond et all., 2004). Social axioms is used to refer that beliefs related to mechanism of world constitute general disposition about values in terms of people (Bond et all., 2004). In this regard, social cynicism is defined as thought composition related social world like having adverse opinion towards humankind, causing to unhappiness by life, being exploited someone by powerful people and being practiced double standard on behalf of the rich by social institutions (Leung et all., 2010). From this perspective, feeling of insecurity towards authorities and institutions step forward in social cynicism (Bateman et all., 1992). This situation can also referred as alienation from socio-economic institutions as a result of violating social contract (Abraham, 2000).

It can be said that this negative psychological view occurs due to life experience in social world and it is conveyed to organization by worker. Social cynicism differentiates from personality cynicism in this respect (Bond et all., 2004).

Occupational cynicism can be defined as attitudes or behaviors stemmed from profession executed by the individual. Specially, it may be asserted that occupational cynicism happens due to professional failures. Niederhoffer tries to explain occupational cynicism through policing. According to Niederhoffer, police officers lose both their confidence and reliance to society when they are unsuccessful (Neiderhoffer, 1968a). In these situations, members of profession are offended; hatred and hostility towards society and feeling of weakness against society may take place. Such that, they can say, “I hate civilians”, which displays their cynical attitude (Neiderhoffer, 1968b).

Employee cynicism, just as in social cynicism, emerges due to contract violation. This contract violation rises to surface because of breaching psychological contact terms like equity, justice and objectivity between employee and employer (Rousseau, 1989). Psychological contract is perception of reciprocal responsibility between employee and employer (Robinson, 1996). In other words, psychological contract that is related to specific conditions and terms between individual and organizational structure is mutual agreement believed by particularly workers as pledged words (Rousseau, 1989).

In addition, psychological contract have wide structure that encompasses unspoken terms that is assumed (Morrison and Robinson, 1997; Peng et all., 2016). In this regard, psychological contract is feeling of inequity, which occurs in workplace, towards great institutional businesses, top executive managers or similar constitutions (Stanley et all., 2005). Unannounced layoffs, lateral transfer instead of vertical promotions, unfulfilled promises of training or travel (Andersson, 1996), lack of

performance-based payment, unfulfilled promises of development (Rousseau, 1990), unfairness on personnel procedures, not supporting with personal and family problems, lack of recognition and feedback on performance (Dainty et all., 2004) are some breaches in context of psychological contract.

Organizational cynicism is investigated in terms of organizational change. Organizational change is referred as finding new methods for organizational schema and its working style (Dawson, 2003). In this context, organizational change cynicism is midrange thought encompassing pessimism about possible unsuccessfulness of organizational change because workers consider that leaders who execute the change is ineligible and lazy (Wanous et all., 1994; Abraham, 2000, Reichers et all., 1997). It is seen that workers have accusatory attitude towards the leaders who conduct organizational change (Brown and Cregan, 2008). It is asserted the fear that working comfortable is removed forcibly causes to develop these attitudes or behaviors (Aslam et all., 2016). From this point of view, it may expressed that organizational change cynicism is a reactional psychological situation.

It is asserted that organization change cynicism is different from skepticism. Thus, although skeptics can guess the unsuccessfulness of organizational change, they may be also hopeful on that some positive developments might take place (Reichers et all., 1997). Organizational change cynicism comes to exist as a belief that new organization change attempts would be fail by regarding unsuccessfulness of previous organization change (Reichers et all., 1997; Ribbers, 2009). Pessimism due to previous failures is example for this circumstance (Rubin et all., 2009; Thompson et all., 2000). Thus, organizational change cynicism is not inherent attitude or behavior ontologically; it arises as a result of experiences (Reichers et all., 1997).

In addition, organizational change cynicism is used as a tool of protecting from negative expressions about that the workers may lose their control on job (Reichers et all., 1997, Barton and Ambrosini, 2013). Therefore, workers do not take responsibilities on the organizational change because they think that reason shown by their current managers is not true and that new manager staff would resolve problems causing organizational change (Reicher et all., 1997). Not taking responsibility on organizational change converts to organizational change resistance in case organizational cynicism is perceived in solidarity (Thompson et all., 2000). The belief that managers pursue hidden or implicit goals, unlike expressed, has role on developing this attitude (Stanley et all., 2005; Grama, 2013). Quality of informing has relation with this situation (Qian and Daniels, 2008). Therefore, explanatory informing would decrease organizational change cynicism (Grama and Todericiu, 2016).

3.2.2. Dimensions of Organizational Cynicism

Organizational cynicism essentially has three dimensions. These are *cognitive*, *emotional* and *behavioral dimensions* of organizational cynicism

Cognitive dimension of organizational cynicism is referred as ideational approach based on the belief. In this context, worker think that organization do not keeps to fundamental principles like justice, honesty and sincerity in cognitive dimension of organizational cynicism (Dean et all., 1998). In this regard, the belief based on that there is unprincipled practices in organization has role on this cognitive approach (Pelit and Pelit, 2014).

Cognitive organizational cynicism also shape cynical attitudes or behaviors (Delken, 2004). Thus, there is a sceptic position that makes worker think altruistic actions or decisions related job process of

organization service to create authority legitimacy and to preserve bureaucratic hierarchy (Dean et all., 1998; Goldner et all., 1977). Indeed, according to workers, manager or co-workers frequently tries to derive benefit via their behaviors seen as altruistic (Kanter and Mirvis, 1989). That is to say, it is quested secret a goal in decisions and actions, which may affect workers negatively. It can seen that some unprincipled practices like injustice, deceit and insincerity, gaining advantage, being unethical are routinized in cognitive organizational cynicism (Işık, 2014).

Emotional organizational cynicism can referred as negative emotions felt towards organization worked. For example, disdain, feeling anger, disgust, feel ashamed for organization are most specific ones. Also, there are emotions like hopeless, disillusionment in this kind of organizational cynicism (Andersson, 1996; Reichers et all., 1997).

These negative emotions develops because of perceiving for superiority in frame of own standards or values that worker demands from organization (Dean et all., 1998). However, these cynical emotions are not disclosed to not lose wage or statue easily (Pelit and Pelit, 2014).

Worker criticizes the approach style of organization by saying snippy words in behavioral organizational cynicism. This critical behavior is performed by estimating the future of organization pessimistically (Dean et all., 1998). To illustrate, the worker in this position can behave cynically by expressing that any investment would be unsuccessful. Main reason of why worker behave like this is that he/she perceives for superiority oneself than organization worked in terms of knowledge and ability. In addition, wry smile or grin are other cynical behaviors wordlessly (Brandes and Das, 2006).

Purpose

The aim of the study is to reveal the role of organizational cynicism for the effect of emotional labor on individual work performance in order to get explanatory results in terms of organizational behavior approaches.

Method

In this study, it was used fieldwork method in order to reveal the role of organizational cynicism for the effect of emotional labor on individual work performance. This study was conducted A, B, C type classified private hospitals of İstanbul. The sample of this research consists of 390 nurses who can contact face to face with patients per 130 for each class under the %5 estimated half width of confidence interval for unknown universe size. Due to financial and time constraint, stratified sampling was chosen. Fundamental presumption of this sampling method is that human resource capacity, bed numbers, financial structure, technological capability and other substructure potentiality of hospitals is not homogeneous and there is no adequate information about universe of the study.

While including nurses to sampling, those who was not in the hospital did not attach to the fieldwork. In addition, leaving blank of at least one expression, duplicate marking and logical mistakes (*like although he/she is under 20 years, those who marks the service life in the occupation as 20 years and above*) is cause of exclusion from the sample.

For this study, it were used three survey that had been conducted reliability and validity test in Turkish version for emotional labor, organizational cynicism and individual work performance respectively (Basım and Begenirbaş, 2012; Kalağan, 2009 and Çöl, 2008).

In scope of this study, following hypothesizes was composed:

H1: *There is a relation between emotional labor and individual work performance.*

H2: *There is a relation between organizational labor and individual work performance.*

H3: *There is a differentiator effect of organizational labor on the relation between emotional labor and individual work performance.*

H4: *There is a difference between emotional labor and age.*

H5: *There is a difference between emotional labor and marital status.*

H6: *There is a difference between emotional labor and gender.*

H7: *There is a difference between emotional labor and educational level.*

H8: *There is a difference between emotional labor and administrative function.*

H9: *There is a difference between emotional labor and the service life in hospital worked.*

H10: *There is a difference between emotional labor and the service life in occupation.*

H11: *There is a difference between organizational cynicism and age.*

H12: *There is a difference between organizational cynicism and marital status.*

H13: *There is a difference between organizational cynicism and gender.*

H14: *There is a difference between organizational cynicism and educational level.*

H15: *There is a difference between organizational cynicism and administrative function.*

H16: *There is a difference between organizational cynicism and the service life in hospital worked.*

H17: *There is a difference between organizational cynicism and the service life in occupation.*

H18: *There is a difference between emotional labor and hospital classes.*

H19: *There is a difference between organizational cynicism and hospital classes.*

Result

In scope of this study, descriptive statistics of nurses about their age, marital status, gender, educational level, administrative function, service life in hospital worked and service life in occupation were presented in following table 1.

Table 1: Socio-demographic data of nurses in the study

Age	n	%
Under 20	40	10
Range 20-29	194	50
Range 30-39	71	18
Range 40-49	55	14
Range 50-59	21	6

Above 59	9	2
Marital Status		
Single	238	61
Married	152	39
Gender		
Male	124	32
Female	266	68
Educational Level		
High School	141	36
Associate Degree	65	17
Bachelor's Degree	134	34
Post Graduate	50	13
Doctoral	0	0
Administrative Function		
Have	313	80
Have not	77	20
Service Life in Hospital Worked		
Under 1 year	122	31
Range 2-5 years	143	37
Range 6-10 years	64	16
Range 11-15 years	36	9

Range 16-20 years	7	2
Above 20 years	18	5
Service Life in Occupation		
Under 1 year	66	17
Range 2-5 years	143	37
Range 6-10 years	65	17
Range 11-15 years	43	11
Range 16-20 years	29	7
Above 20 years	44	11

For reliability of emotional labor, individual work performance and organizational cynicism, Cronbach alpha values were shown at table 2.

Table 2: Reliability of Variables

Variables	**Cronbach α**
Emotional Labor	,8528
Individual Work Performance	,8664
Organizational Cynicism	,9308

According to table 2, it is seen that all variables in this study is reliable for measurement

Table 3: Validity Test for Emotional Labor

	Surface Acting (Explained Variance = % 33,92)	**Deep Acting (Explained Variance = % 22,20)**	**Natural Acting (Explained Variance = % 19,68)**	**Cronbach α**
EL 1	,846			
EL 2	,886			
EL 3	,852			

EL 4	,867			**0,92**
EL 5	,856			
EL 6	,759			
EL 7		,721		**0,86**
EL 8		,889		
EL 9		,799		
EL 10		,801		
EL 11			,901	**0,90**
EL 12			,887	
EL 13			,865	
Bartlett Test Results		Total Explained Variance (%)	**75,81**	
		Kaiser-Mayer-Olkin (KMO)	**0,863**	
		Degrees of freedom	**78**	
		Ki-kare value	**3581,301**	
		P	**0,00**	

According to explanatory factor analyses, there are there dimension and there is no double item. EL 1, EL 2, EL 3, EL 4, EL 5, EL 6 factors are under the surface acting, EL 7, EL 8, EL 9, EL 10 factors are under the deep acting and EL 11, EL 12, EL 3 are under the natural acting of emotional labor. According to KMO sample test result (0,86), the size of the sample for emotional labor is adequate as "good". In addition, according to Bartlett test result ($p<0,05$), emotional labor variable is suitable to conduct factor analyses in terms of validity.

Table 4: Validity Test for Individual Work Performance

	Individual Work Performance	**Cronbach α**
IWP 1	,893	**,86**
IWP 2	,867	
IWP 3	,831	
IWP 4	,792	

Bartlett Test Results	Total Explained Variance (%)	**71,67**
	Kaiser-Mayer-Olkin (KMO)	**,818**
	Degrees of freedom	**6**
	Ki-kare value	**759,824**
	P	**0,00**

For individual work performance, which was scaled as single factor, there is no double item. According to KMO sample test result (0,81), the size of the sample for individual work performance is adequate as "good". In addition, according to Bartlett test result (p<0,05), individual work performance variable is suitable to conduct factor analyses in terms of validity.

Table 5: Validity Test for Organizational Cynicism

	Cognitive Organizational Cynicism (Explained Variance = % 27,29)	**Emotional Organizational Cynicism = % 26,85)**	**Behavioral Organizational Cynicism = % 22,12)**	**Cronbach α**
OC 1	,814			**0,88**
OC 2	,821			
OC 3	,769			
OC 4	,728			
OC 5	,720			
OC 6		,788		**0,93**
OC 7		,862		
OC 8		,846		
OC 9		,770		
OC 10			,905	**0,87**
OC 11			,860	
OC 12			,694	
OC 13			,634	

Bartlett Test Results	Total Explained Variance (%)	**76,27**
	Kaiser-Mayer-Olkin (KMO)	**,919**
	Degrees of freedom	**78**
	Ki-kare value	**3831,775**
	P	**0,00**

According to explanatory factor analyses, there are there dimension and there is no double item. OC 1, OC 2, OC 3, OC 4, OC 5, factors are under the cognitive organizational cynicism, OC 6, OC 7, OC 8, OC 9 factors are under the emotional organizational cynicism and OC 10, OC 11, OC 12, OC 13 are under the behavioral organizational cynisim. According to KMO sample test result (0,91), the size of the sample for organizational cynicism is adequate as " very good". In addition, according to Bartlett test result ($p<0,05$), organizational cynicism variable is suitable to conduct factor analyses in terms of validity. As a result, emotional labor, individual work performance and organizational cynicism scales are reliable and valid in context of their original structure.

For hypothesis analyze, dependent and independent variable's mean, median and standard deviation values were shown at following tables.

Table 6: Emotional Labor Factors

Emotional Labor	Mean	Median	St. Deviation
Surface Acting	2,28	2,00	1,06
Deep Acting	3,12	3,00	1,08
Natural Acting	2,45	2,33	1,12
General Point	2,86	2,92	0,76

According to table 6, it is seen that mean of surface acting is 2,28 ± (1,06), mean of deep acting is 3,12 ± (1,08) and mean of natural acting is 2,45 ± (1,12).

Table 7: Individual Work Performance

	Mean	Median	St. Deviation
Individual work performance	4,05	4,00	0,77

According to table 7, it is seen that the mean of individual work performance, which was scaled as single factor, is 4,05 ± (0,77).

Table 8: Organizational Cynicism

Organizational Cynicism	Mean	Median	St. Deviation
Cognitive organizational c.	2,67	2,70	1,00
Emotional organizational c.	2,24	2,00	1,14
Behavioral organizational c.	2,39	2,25	1,07
General Point	2,45	2,38	0,91

According to table 8, it is seen that the mean of cognitive organizational cynicism is 2,67 ± (1,00), the mean of emotional organizational cynicism is 2,24 ± (1,14) and behavioral organizational cynicism is 2,39 ± (1,07).

Table 9: One Sample Kolmogorov-Smirnov test

	Emotional Labor	Individual Work Performance	Organizational Cynicism
Test Statistic	,056	,106	,077
P	,005	,000	,000

When viewed table 6, table 7, table 8 and table 9, it is accepted that variables are non-parametric in terms of mean, median and standard deviation values of variables in this study and Kolmogorov-Smirnov test results.

Table 10: Correlation Test Results (Spearman Correlation)

		Individual Work Performance
Emotional Labor	r	,067
Surface acting	r	**-,144****

Deep acting	r	**,100***
Natural acting	r	-,014
Organizational Cynicism	r	-,098
Cognitive organizational cynicism	r	-,081
Emotional organizational cynicism	r	**-,158***
Behavioral organizational cynicism	r	-,042

** Statistical significance level at p<0,01.
* Statistical significance level at p<0,05 .

According to results of table 10, while there is poor negative positive relation between surface acting and individual work performance, there is poor positive relation between deep acting and individual work performance statistically. In the light of these results, it could not found direct relation between emotional labor and individual work performance. Thus, H_1 hypothesis was rejected.

Also, it was found that there is poor negative relation between emotional organizational cynicism and individual work performance. According to these results, there is no direct relation between organizational cynicism and individual work performance. Thus, H_2 hypothesis was rejected.

Because H_1 and H_2 was rejected, H_3 hypothesis could not tested in terms of research methods. Also, because relation values are poor regression analysis could not tested. Thus, H_3 hypothesis was rejected. In addition; it is presented that other statistical test results to examine other hypothesis at table 11, table 12, table 13 and table 14.

Table 11: Kruskal Wallis Test Results

	Emotional Labor			Organizational Cynicism		
	χ^2	df	P	χ^2	df	P

Age	14,307	5	**0,010***	15,101	5	**0,010***
Educational Level	2,323	3	0,508	15,069	3	**0,002***
Service Life in Hospital Worked	2,821	5	0,728	12,332	5	**0,031***
Service Life in Occupation	16,870	5	**0,005***	4,630	5	0,463
Hospital Class	12,217	2	**0,002***	9,803	2	**0,007***

Research results shows that there is a difference among age's and hospital class's sub groups for both emotional labor and organizational cynicism. In addition, it is found that there is a difference among educational level's and service life in worked hospital's sub groups for organizational cynicism. Finally, it was found that there is a difference among service life occupation's sub groups for emotional labor. According to these results; H_4, H_{10}, H_{11}, H_{14}, H_{16}, H_{18}, H_{19} hypothesis was approved. In addition, Bonferroni correction was done in order to specify the difference among which sub groups are.

Table 12: Bonferroni Corrections (Mann Whithey-U) for Emotional Labor

	Age	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
Emotional Labor	20-29 age 50-59 age	194 21	2,91 2,37	0,70 0,90	2,96 2,07	112,50 66,43	**1164,00**	**-3,227**	**0,001***
	40-49 age 50-59 age	55 21	3,03 2,37	0,75 0,90	3,00 2,07	43,48 25,45	**303,500**	**-3,186**	**0,001***
	Service Life in Occupation	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	2-5 years 20 years	143	2,94 2,53	0,64 0,83	2,92 2,57	100,97	**2149,00**	**-3,22**	**0,001***

	and above	44				71,34		**7**	
	16-20 years 20 years and above	29 44	3,21 2,53	0,94 0,83	3,23 2,57	46,12 30,99	**373,500**	**-2,984**	**0,003***
	Hospital Class	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	A Class B Class	130 130	2,62 2,34	0,86 0,96	2,53 2,11	146,08 114,92	**6425,00**	**-3,342**	**0,001***
	B Class C Class	130 130	2,34 2,94	0,96 0,76	2,11 2,92	118,85 142,15	**6935,00**	**-2,501**	**0,012***

As a result of the Bonferroni correction (under the terms of p<0,05/**6**[3]=0,008), it was found that significant difference between "20-29 age range" and "50-59 age range" in favor of those who is in "20-29 age range" and between "40-49 age range" and "50-59 age range" in favor of those who is in "40-49 age range".

Similarly, as s results of Bonferroni correction (under the terms of p<0,05/6=0,008) for service life in occupation, it was found that significant difference between "20 years and above" and "2-5 years" and, between "20 years and above" and "16-20 years" against the those who in "20 years and above" for both each comparison.

Finally, as s results of Bonferroni correction (under the terms of p<0,05/3=0,016) for hospital class, it was found that significant difference between "A class" and "B class", and between "B class" and "C class" against those who works in "B class" for both each comparison.

[3] It defines the number of sub group for each variable in order to perform Bonferroni correction properly.

Table 13: Bonferroni Corrections (Mann Whithey-U) for Organizational Cynicism

	Age	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
Organizational Cynicism	Under the 20 age 20-29 age	40 194	2,14 2,49	0,95 0,81	1,84 2,38	112,50 66,43	**2780,50**	**-2,822**	**0,005***
	Under the 20 age 40-49 age	40 55	2,14 2,67	0,95 0,97	1,84 2,53	39,00 54,55	**740,00**	**-2,715**	**0,007***
	Educational Level	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	High school Bachelor's degree	141 134	2,22 2,54	0,84 0,89	2,07 2,53	123,56 153,19	**7411,00**	**-3,091**	**0,002***
	High school grd. Post graduate	141 50	2,22 2,60	0,84 0,87	2,07 2,46	89,54 114,23	**2613,50**	**-2,716**	**0,007***

	Service Life in Hospital Worked	N	Mean	St. Deviation	Median	Mean Rank	U	Z	P
	0-1 years 6-10 years	112 64	2,33 2,76	0,85 0,90	2,30 2,69	84,83 110,03	**2826,00**	**-3,035**	**0,002***
	2-5 years 6-10 years	143 64	2,37 2,76	0,85 0,90	2,23 2,69	96,21 121,40	**3462,50**	**-2,797**	**0,005***
	Hospital Class	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	A Class B Class	130 130	2,62 2,34	0,86 0,96	2,53 2,11	144,47 116,53	**6634,00**	**-2,997**	**0,003***

As a result of the Bonferroni correction (under the terms of p<0,05/6=0,008), it was found that significant difference between “under the 20 age” and “20-29 age range” and, between “under the 20 age” and “40-49 age” against the those who in under

Similarly, as s results of Bonferroni correction (under the terms of p<0,05/4=0,0125) for educational level, it was found that significant difference between “high school graduate” and “bachelor’s degree” and, between “high school graduate” and “post graduate” against those who in “high school graduate” for both each comparison.

In addition, as s results of Bonferroni correction (under the terms of p<0,05/6=0,008) for service life in hospital worked, it was found that significant difference between “0-1 years” and “6-10 years” and, between “2-5 years” and “6-10 years” in favor of those who in “6-10 years” for both each comparison.

Finally, as s results of Bonferroni correction (under the terms of p<0,05/3=0,016) for hospital class, it was found that significant difference between “A class” and “B class” in favor of those who works in “A class”.

Table 14: Mann Whithey-U test for Organizational Cynicism and Emotional Labor

	Marital Status	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
Emotional Labor	Married Single	152 238	2,89 2,85	0,83 0,71	2,92 2,92	198,44 193,62	**17641,50**	**-0,412**	**,458**
	Gender	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Male Female	124 266	2,86 2,86	0,78 0,75	2,92 2,92	197,67 194,49	**16222,50**	**-0,261**	**,795**
	Administrative Function	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Have Have not	77 313	2,97 2,84	0,72 0,75	3,00 2,92	209,06 192,16	**11006,00**	**-1,180**	**,238**
Organizational Cynicism	**Marital Status**	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Married Single	152 238	2,42 2,47	0,95 0,88	2,92 2,92	189,61 199,26	**17192,50**	**-0,825**	**,409**

	Gender	N	Mean	St. Deviation	Median	Mean Rank	U	Z	P
	Male Female	124 266	2,49 2,44	0,99 0,87	2,34 2,38	197,21 194,70	**16279,50**	**-0,205**	**,838**
	Administrative Function	**N**	**Mean**	**St. Deviation**	**Median**	**Mean Rank**	**U**	**Z**	**P**
	Have Have not	77 313	2,51 2,44	0,84 0,92	2,38 2,38	204,05 193,40	**11392,00**	**-0,743**	**,458**

According table 14, there is no any significant difference between dependent and independent variables. Hence, marital status, gender and administrative function of nurses do not affect their emotional labor and organizational cynicism attitudes. In this regard, H_5, H_6, H_7, H_8, H_9, H_{11}, H_{12}, H_{13}, H_{15} and H_{17} hypothesis were rejected.

Conclusion

Research results shows that there is no relation between emotional labor and individual work performance. However, it is seen that there is a significant poor relation between surface acting and individual work performance negatively. The result that surface acting decreases individual work performance is congruent with other study results (Akhter, 2016; Ghalandari et all., 2012). It can asserted that the necessity to display emotions by putting on false self in emotional labor is a reason of this negative relation between surface acting and individual work performance. Therefore, this kind of emotional labor includes hard and wearing process that workers convert themselves emotionally. In addition, this result can be interpreted as that workers do not perceive surface acting as concern of professionalism.

As congruent with other research results in academic literature, it was found that deep acting increases individual work performance (Akhter, 2016; Ghalandari et all., 2012; Gelderen et all., 2017). In

addition, this research result is also parallel with another result that there is relation between deep acting and adaptive performance as part of individual work performance (Wang et all., 2016; Gelderen et all., 2017).

As different from the result of Akhter's (Akhter, 2016), there is no relation between natural acting and individual work performance. This situation can be interpreted as that natural acting is kind of behavior that may be displayed in also other social areas outside working life. Therefore, it should be acknowledged that understanding the difference between natural acting displayed in working life and emotional reflexes displayed in other social areas, and comprehending the probable contribution of natural acting to individual work performance are so hard.

Another prominent concept is organizational cynicism. Research results, as different from some academic results, (Supriadi and Sefnedi, 2017), show that there is no relation between organizational cynicism and individual work performance. Although emotional organizational cynicism was expressed at the least compared with other organizational cynicism types, it has negative effect on individual work performance as different from cognitive and behavioral organizational cynicism. In spite of the negative effect of emotional organizational cynicism on individual work performance, the reason why there is no relation organization cynicism and individual work performance can be interpreted as that having cynical attitudes does not contuse professional and personal liability.

It is known Industry 4.0 (**The Fourth Industrial Revolution) that is dominated by** digitalization, artificial intelligence and robots have **been getting near. In this regard, it is considered that this circumstance will lift its effectiveness in healthcare sector as in every sector. Therefore, it can be thought characteristics of emotional labor in context of being brought the fore of the talents and abilities monopolized by the labor have distinctive** role. Otherwise, being institutionalized of labor knowledge would vulgarize the labor (Braverman, 1974).

Economic system that is on the verge of preferring robots or human, if humankind does not locate their role again with emotional labor behaviors that can be displayed by human only as seen in this study, would choose robots with a high degree of probability. This situation is likely to cause diminishing of the needs for healthcare staff notably nurses. Therefore, this study lays emphasis on the emergency of that nurses should be worked in same organization in long term by increasing their emotional labor values. Decreasing organizational cynicism would be possible by recognizing workers in organizational decision point and process, which affect to them directly. Therefore, it is not enough to create working culture by declaring the organizational rules and mission for it. In this context, health managers who internalize communication techniques have pivotal role to achieve this aim.

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