Received: 28 May 2024 | Revised: 22 July 2024 | Accepted: 20 August 2024

DOI: 10.1111/jep.14136

ORIGINAL PAPER

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research
WILEY

Psychometric analysis of the quiet quitting and quiet firing scale among Turkish healthcare professionals

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Abstract

Background: Due to the impact of the COVID-19 pandemic, the risk of quiet quitting among healthcare professionals is increasing. Individuals who engage in the quiet quitting process may also unknowingly become the target of quiet firing. The concepts of quiet quitting and quiet firing play a crucial role in promoting employee resilience and preventing organizational losses.

Method: This study aimed to conduct a validity and reliability analysis of the quiet quitting and quiet firing scale (QQ and QF scale) in Turkish. A methodological study was conducted with 445 healthcare professionals.

Results: The item-total score correlation values ranged between 0.37 and 0.76. The confirmatory factor analysis confirmed a 14-item, two-factor structure. Cronbach's α internal consistency coefficient was 0.89. The QQ and QF scale had a strong negative correlation with the person-organization fit scale and the happiness at work scale subscales of engagement, job satisfaction and affective organizational commitment.

Conclusion: The results showed that the adapted version of the QQ and QF scale was valid and suitable for use in Turkey.

KEYWORDS

healthcare, nursing, quiet firing, quiet quitting, reliability, validity

1 | INTRODUCTION

The COVID-19 pandemic and the subsequent 'great resignation' have resulted in the emergence of the 'quiet quitting' and 'quiet firing' concepts.[1] Although the phenomenon of quiet quitting was initially perceived as a trend, it appears to be a global phenomenon when considering the scope of its impact globally.[2] The Gallup report revealed that at least half of the workforce in the United States of America is in the quiet quitting process.[3] In addition, a recent LinkedIn News survey conducted in the United States of America reported that the majority of respondents had either observed or experienced quiet firing in their workplace.[4] Although there are limitations in the research conducted in Turkey, according to Youthall's research, 24% of young individuals in Turkey are engaged in this process and 46.6% feel recipient to the quiet quitting process.[5]

1.1 | Quiet quitting

Quiet quitting is a term that describes employees limiting their commitment only to assigned tasks and working to meet the requirements of the job description without engaging in any additional work.[6] Employees who begin the process of quiet quitting may exhibit behaviours such as leaving the workplace early, arriving at

work late, refusing to engage in work outside working hours, demonstrating a lack of interest in assisting coworkers, and resisting going above and beyond minimum job duties.[7] While the COVID-19 pandemic has clearly had a significant impact on this process, there are a number of other reasons why employees place restrictions on their work, including a lack of value, appreciation, financial incentives, and support, burnout, the exclusion of employees from corporate decision-making, a lack of autonomy at work and decreased trust in the organization.[8–11] In addition, increasing living costs and insufficient retirement savings can also contribute to quiet quitting.[12]

Individuals who are in the process of quiet quitting are emotionally detached from their jobs. This is a factor that profoundly impacts healthcare services. Although the quiet quitting process, which results in reduced productivity, increased employee turnover and decreased work quality, as well as negative consequences for patient safety and satisfaction, helps employees avoid burnout, it can jeopardize their career advancement.[6,13] Furthermore, employees who engage in the quiet quitting process may unknowingly become the target of quiet firing.[14]

1.2 | Quiet firing

Quiet firing is defined as a situation where an employer purposefully creates a negative work environment that causes employees to voluntarily resign.[15] Examples of difficulties that lead to this process include turning down employees' requests for promotions or salary increases, providing unconstructive feedback, excluding employees from important meetings, decisions and social activities, asking employees to work overtime and increasing their workload to levels that cannot be effectively managed. Employees who feel isolated, disconnected, devalued and unappreciated are much less likely to perform well in their positions. Failure to address this issue can jeopardize the operational efficiency of the workplace.[4,16]

Quiet quitting and quiet firing negatively affect employee and organizational performance, causing major economic losses across the world. More research is needed to help organizations navigate this new workplace reality by understanding the antecedents and consequences of quiet quitting and firing processes.[8,10,17] The COVID-19 pandemic has brought about changes in working conditions and ways of conducting business across all sectors. Among individuals in their profession, healthcare professionals have experienced the most substantial transformation. They have encountered various challenges since the onset of the pandemic, including the risk of infection, negative working conditions, increased workload and wage inequalities, physical and verbal violence, anxiety, depression, burnout, limitations on resignation and annual leave and disruption of work-life balance.[6,7] Although the pandemic process has its effects, many factors, especially factors in working conditions, continue to affect the quite quitting process of healthcare professionals. However, there is limited research investigating the quiet quitting levels of healthcare professionals and nurses.[18–22] In this context, the current study aimed to conduct a validity and reliability analysis of the quiet quitting and quiet firing scale (QQ and QF scale) in a sample of Turkish healthcare professionals. To this end, answers were sought to the following research questions:

1. Is 'Quiet Quitting and Quiet Firing Scale' a valid measurement tool to be used to evaluate the quiet quitting and quiet firing levels of healthcare professionals?
2. Is 'Quiet Quitting and Quiet Firing Scale' a reliable measurement tool to be used to evaluate the quiet quitting and quiet firing levels of healthcare professionals?

2 | METHODOLOGY

2.1 | Procedure

The Turkish validity and reliability assessment of the QQ and QF scale was carried out in accordance with the International Test Commission guidelines.[23] Language, content, construct, concurrent and known-groups validity analyses were undertaken to assess scale validity, while item-total score correlation, internal consistency and response consistency analyses were employed to evaluate scale reliability.

Language validity: The scale items whose equivalence was established were translated from English to Turkish by three translators who spoke English as a native language and had knowledge about the culture into which the instrument was adapted. Subsequently, English-speaking experts evaluated the translated items from a cultural perspective by comparing them with the original versions. After the expert evaluation phase, the researchers evaluated the statements on the scale and finalized the Turkish version of the scale. The final scale items were back-translated into English by three linguists who are native speakers of both languages. The researchers analysed the original and back-translated scale items and ensured the language validity of the scale in light of the views of a Turkish language expert.[23]

Content validity: To establish the content validity of the scale, the opinions of eight academicians who hold doctoral degrees in nursing and four specialist physicians in Turkey were sought. The Davis technique (1992) was used to assess content validity. The experts evaluated each item on the scale as (a) 'appropriate', (b) 'in need of slight revision', (c) 'in need of serious revision' and (d) 'not appropriate'. The content validity index was calculated by dividing the number of experts who marked options a and b for each item by the total number of experts who provided their opinions for the item. The content validity index values of the scale items varied between 0.86 and 1.[24] The researchers revised the scale items in line with expert opinions and finalized the scale (File S1).

2.2 | Sample

To reveal the factor structure in scale studies, it is recommended to have a sample size of at least 300 or above.[23] To achieve maximum

diversity, healthcare professionals working in seven regions of Turkey were reached using the snowball method. The criteria for inclusion in the study were as follows: (a) Working as a healthcare professional, (b) having professional experience for at least 1 year and (c) volunteering to participate in the study. The sample of the study consisted of 445 healthcare professionals, from whom data was collected.

The mean age of the individuals in the sample was 32.07 ± 7.48 years. Of the participants, 65.8% were male, 56% were married, 58.0% had children, 49% had a bachelor's degree, 54.4% were nurses, 36.0% worked in the emergency department, 64.3% worked in shifts, 62.7% worked in public hospitals and 59.6% worked in the Marmara region of Turkey. The mean duration of professional experience was 9.39 ± 7.24 years, the mean duration of institutional experience was 5.64 ± 5.14 years and the mean monthly working hours was 203.54 ± 75.06 (File S2).

2.3 | Measures

Personal information form: This form consisted of a total of 15 questions about the healthcare professionals' age, gender, marital status, status of having children, profession, educational status, working status, monthly working hours, work schedule, unit at which they worked, position, duration of institutional experience, duration of employment in the current unit, duration of professional experience and the region of residence.

QQ and QF scale: This scale was developed by Anand et al. and consists of 14 items and two subscales. The first subscale quite quitting intentions contains Items 1–7, and the second subscale perceived quiet firing contains Items 8–14. Cronbach's α coefficient was found to be 0.829 for the quite quitting intentions subscale and 0.876 for the perceived quiet firing subscale. A higher score obtained from these subscales is interpreted to indicate higher levels of quiet quitting and firing.[25]

Happiness at work scale: This scale, developed by Salas-Vallina and Alegre[26] and adapted into Turkish by Bilginoğlu and Yozgat,[27] was used to assess the concurrent validity of the Turkish QQ and QF scale. It is based on a five-point Likert type and consists of nine items. The scale consists of three subdimensions: engagement, job satisfaction and organizational commitment. The Cronbach's α reliability coefficient of the scale is 0.89. As the score obtained from the scale increases, the level of happiness at work also increases.[27] In the current study, the Cronbach's α reliability coefficient of the scale was determined to be 0.874.

Person-organization fit scale: The original scale was developed by Netemeyer et al.,[28] and the validity and reliability analyses of the Turkish version were undertaken by Turunç and Çelik.[29] The scale consists of four items and has a Cronbach's α reliability coefficient of 0.81.[29] A higher score on the scale represents a higher level of person-organization fit. In the current study, the Cronbach's α reliability coefficient was calculated to be 0.907.

2.4 | Data collection

Data was collected with the online survey method using Google Forms between November 2023 and January 2024. The online data collection tool was shared with healthcare professionals via WhatsApp, and the data collection phase was completed with the snowball method.

2.5 | Data analysis

The data obtained from the study was analysed using the SPSS version 25.0 for Windows (SPSS Inc.) and Lisrel 8.54 (Scientific Software International, 2003) statistical packages. The type I error was accepted as 5%. Validity was evaluated through exploratory and confirmatory factor analyses, known-groups validity and concurrent validity approaches, while reliability analysis was undertaken with item analysis and internal consistency methods.

2.6 | Ethical considerations

To conduct the validity and reliability analyses of the Turkish version of the scale, written permission was received via e-mail from Anand, who developed the original QQ and QF scale. The informed consent form was included on the first page of the online data collection tool. Individuals who agreed to participate in the research were asked to read the form and confirm their voluntary participation before proceeding to the other pages of the data collection tool. The principles of the Declaration of Helsinki were followed at every stage of the research.

3 | RESULTS

3.1 | Descriptive findings of the QQ and QF scale

The participants' mean score on the QQ and QF scale was 3.28 ± 0.82. The average of the perceived quiet firing subscale is 3.16 ± 0.97 and the average of the quiet quitting intentions subscale is 3.40 ± 0.84. Participants received the highest score with the first questioning 'My manager/supervisor has increased my workload, but no raise or increase in pay', the second questioning 'I often avoid working more hours, if there is no additional pay' (3.70 ± 1.27 and 3.63 ± 1.29, respectively). Upon examining the distribution of the items and the total score individually, it was determined that none of the distributions were skewed (<1.0), and similarly, there was no kurtosis problem for any of the items (values were in the range of −1.0 to 1.0). The base percentage, expressed as the percentage of individuals who received the lowest possible score on the scale, was very good (0.7–11.6) for both subscales and the total score (Table 1).

TABLE 1 Descriptive characteristics and internal consistency findings of the QQ and QF scale.

	Corrected item-total correlation	Cronbach's α if item deleted	X ± SD
Perceived quiet firing		0.880	3.16 ± 0.97
QF1. My manager/supervisor gives me limited time off from work.	0.65	0.87	3.24 ± 1.35
QF2. My manager/supervisor has increased my workload, but no raise or increase in pay.	0.60	0.87	3.70 ± 1.27
QF3. My manager/supervisor has demanded to work after hours.	0.64	0.87	2.93 ± 1.32
QF4. My manager/supervisor has excluded me or kept me out of the loop in work/social events.	0.59	0.87	2.41 ± 1.16
QF5. My manager/supervisor has a lack of respect for my contributions.	0.76	0.85	3.18 ± 1.26
QF6. My manager/supervisor fails to give recognition for my performance.	0.76	0.85	3.40 ± 1.22
QF7. My manager/supervisor has shown less interest in my career trajectory/development.	0.71	0.86	3.31 ± 1.23
Quiet quitting intentions		0.790	3.40 ± 0.84
QQ1. I often avoid working more hours, if there is no additional pay.	0.37	0.79	3.63 ± 1.29
QQ2. I am doing the bare minimum work to avoid being fired.	0.44	0.79	2.79 ± 1.47
QQ3. I feel there is a lack of opportunities to learn and grow in my organization.	0.52	0.77	3.58 ± 1.17
QQ4. I feel there is a lack of meaningfulness at work.	0.59	0.76	3.30 ± 1.20
QQ5. I feel I have a lack of interest in attending meetings.	0.64	0.75	3.41 ± 1.19
QQ6. I feel there is a lack of passion and enthusiasm in me to work above and beyond.	0.58	0.76	3.57 ± 1.18
QQ7. I feel there is a lack of feeling regarding my employer's caring for me.	0.57	0.76	3.60 ± 1.21
TOTAL		0.890	3.28 ± 0.82

Abbreviations: QQ and QF scale, quiet quitting and quiet firing scale; SD, standard deviation; X, mean.

3.2 | Construct validity

3.2.1 | Exploratory factor analysis

Before applying exploratory factor analysis, the suitability of the sample size and items for factor analysis was tested. According to the Kaiser–Meyer–Olkin (KMO) value (0.918) and the Bartlett sphericity test result ($\chi^2[91] = 2930.489$, $p = 0.000$), it was concluded that the sample size and items were sufficient to perform factor analysis.[30] To examine the factor structure of the scale, exploratory factor analysis was performed using the principal component analysis and varimax rotation methods. The factor pattern for all items was examined, and exploratory factor analysis was performed by forcing the number of factors in a way that would not disrupt the original structure of the scale. The scale was evaluated as having two factors, and the factor pattern was found to be acceptable. According to the results of the exploratory factor analysis, the adapted scale explained 54.319% of the total variance. In addition, the first factor explained 30.785% of the total variance, and the second factor explained 23.534% of the total variance (Table 2).

3.2.2 | Confirmatory factor analysis

According to the results of the confirmatory factor analysis, the scale was found to be significant at the structural equation model level ($p = 0.000$). It was determined that the 14 items and the two subscales were related to the scale structure (File S3). After evaluating the goodness-of-fit indices of the scale, it was determined that the scale had an acceptable fit (Table 3).

3.3 | Convergent and discriminant validity

The examination of the correlation between the QQ and QF scale and its subscales revealed a strongly significant positive correlation

TABLE 2 Results of the exploratory factor analysis of the quiet quitting and quiet firing scale.

Factors	Perceived quiet firing	Quiet quitting intentions
QF1	0.772	
QF2	0.670	
QF3	0.729	
QF4	0.701	
QF5	0.766	
QF6	0.737	
QF7	0.687	
QQ1		0.572
QQ2		0.581
QQ3		0.615
QQ4		0.676
QQ5		0.681
QQ6		0.693
QQ7		0.520
Eigenvalue	4.310	3.295
Explained variance	30.785	23.534
KMO = 0.918; $\chi^2(91) = 2930.489$; Bartlett's sphericity test (p) = 0.000		
Total explained variance = 54.319		

Abbreviations: KMO, Kaiser–Mayer–Olkin; QQ and QF scale, quiet quitting and quiet firing scale.

between the overall scale score and the QQ ($r = 0.88$, $p < 0.001$) and QF ($r = 0.92$, $p < 0.001$) subscale scores.

3.4 | Concurrent validity

There was a strongly significant negative correlation between the total QQ and QF scale score and the happiness at work scale score ($r = -0.62$, $p < 0.001$), and a strongly significant negative correlation between the total QQ and QF score and the person-organization fit scale score ($r = -0.55$, $p < 0.001$) (Table 4).

3.5 | Known-groups validity

In the linear regression analysis performed with the Enter method, marital status, professional experience, duration of institutional experience, region of residence, the happiness at work scale score and the person-organization fit scale score were found to be significantly related to the QQ and QF scale score. These variables included in the model explained 48% of the variance in the QQ and QF scale score ($R^2 = 0.535$, adjusted $R^2 = 0.485$, $F = 10.800$, $p = 0.000$, Durbin Watson statistic = 1.783).

TABLE 3 Results of the confirmatory factor analysis.

Index	Good fit	Acceptable fit	Results
X^2/SD	$0 \le \chi^2/df \le 3$	$3 \le \chi^2/df \le 5$	4.010
RMSEA	0.00 ≤ RMSEA ≤ 0.05	0.05 ≤ RMSEA ≤ 0.08	0.08
SRMR	0.00 ≤ SRMR ≤ 0.05	0.05 ≤ SRMR ≤ 0.08	0.054
CFI	0.97 ≤ CFI ≤ 1.00	0.90 ≤ CFI	0.955
GFI	0.90 ≤ GFI ≤ 1.00	0.85 ≤ GFI	0.885
AGFI	0.90 ≤ AGFI ≤ 1.00	0.85 ≤ AGFI	0.851
NFI	0.95 ≤ NFI ≤ 1.00	0.90 ≤ NFI	0.940

Abbreviations: AGFI, adjusted goodness-of-fit index; CFI, comparative fit index; GFI, goodness-of-fit index; NFI, normed fit index; RMSEA, root mean square error of approximation; X^2/SD, degrees of freedom.

TABLE 4 Correlation between the QQ and QF scale, happiness at work scale and person-organization fit scale.

	Happiness at work scale	Person-organization fit scale
Quiet quitting intentions	−0.624*	−0.554*
Perceived quiet firing	−0.528*	−0.523*
Total QF and QQ scale	−0.627*	−0.554*

Abbreviation: QQ and QF scale, quiet quitting and quiet firing scale.
*$p < 0.001$

The QQ and QF scale score was significantly higher among the participants who were single (95% confidence interval [CI]: 0.209–1.175), those with children (95% CI: −1.458 to −0.070), and those working in the Eastern Anatolia and Central Anatolia regions of Turkey (95% CI: −0.127 to −0.038). Furthermore, the QQ and QF scale scores increased as age (95% CI: 0.001–0.059) and duration of institutional experience (95% CI: 0.009–0.046) increased and professional experience (95% CI: −0.065 to −0.003), engagement (95% CI: −0.243 to −0.012), job satisfaction (95% CI: −0.376 to −0.064), affective emotional commitment (95% CI: −0.283 to −0.015) and person-organization fit (95% CI: −0.312 to −0.003) decreased (Table 5).

3.6 | Item-total score correlation

Cronbach's α value did not increase when any item was removed from the subscales or the overall scale, and corrected item-total correlations varied between 0.37 and 0.76 (Table 1).

3.7 | Internal consistency

Cronbach's α value was determined to be 0.890 for the overall QQ and QF scale, 0.790 for the quite quitting intentions subscale and 0.880 for the perceived quiet firing subscale (Table 1).

TABLE 5 Linear regression analysis of certain variables and the QQ and QF scale score.

Variable	β	Standard error	Standardized β	t	p	95% CI Lower	95% CI Upper
Constant	4.004	0.711		5.628	0.000	2.59	5.40
Age	0.030	0.015	0.228	2.056	0.041	0.001	0.059
Gender	0.204	0.110	0.122	1.857	0.065	−0.013	0.421
Marital status	0.692	0.245	0.161	2.829	0.005	0.209	1.175
Having children	−0.764	0.352	−0.118	−2.173	0.031	−1.458	−0.070
Number of children	0.057	0.071	0.048	0.808	0.420	−0.083	0.197
Profession	0.024	0.035	0.044	0.671	0.503	−0.046	0.094
Education level	0.065	0.050	0.087	1.304	0.194	−0.033	0.163
Unit of employment	−0.055	0.042	−0.117	−1.283	0.201	−0.138	0.029
Work schedule	0.025	0.067	0.030	0.378	0.706	−0.107	0.158
Institution of employment	0.034	0.054	0.043	0.627	0.532	−0.073	0.140
Duration of professional experience	−0.034	0.016	−0.250	−2.177	0.031	−0.065	−0.003
Duration of institutional experience	0.028	0.010	0.197	2.892	0.004	0.009	0.046
Monthly working hours	0.000	0.000	0.015	0.273	0.785	−0.001	0.898
Region of employment	−0.083	0.023	−0.219	−3.666	0.000	−0.127	−0.038
Engagement	−0.128	0.059	−0.146	−2.176	0.031	−0.243	−0.012
Job satisfaction	−0.220	0.079	−0.220	−2.782	0.006	−0.376	−0.064
Organizational commitment	−0.149	0.068	−0.183	−2.202	0.029	−0.283	−0.015
Person-organization fit	−0.158	0.078	−0.162	−2.012	0.046	−0.312	−0.003

Abbreviations: CI, confidence interval; QQ and QF scale, quiet quitting and quiet firing scale.
$R^2 = 0.535$, adjusted $R^2 = 0.485$, $F = 10.800$, $p = 0.000$, Durbin Watson statistic = 1.783.

4 | DISCUSSION

In this study, in which the QQ and QF scale was adapted into Turkish, first the language adaptation and then the validity and reliability analysis stages of the scale were carried out. Exploratory and confirmatory factor analyses were performed to test construct validity. According to the exploratory factor analysis, the adapted scale explained 54.31% of the total variance. In the original scale study, the scale explained 58.40% of the total variance.[25] An essential requirement in factor analysis is that the amount of variance explained should be greater than 50% of the total variance.[31] Accordingly, it is evident that the established factor structure met the basic criterion.

During confirmatory factor analysis, it is decided whether the model is consistent with the theory according to the results of various fit indices. Upon analysing the fit index values in the current study, it was determined that the construct validity of the scale was ensured.[32,33] The item-total test correlation values of all items were above 0.30, indicating that all items were related to each other.[30] A reliability analysis was undertaken to test whether the statements on the scale were consistent with each other. According to the results, the reliability coefficients were significantly above the minimum threshold of 0.70.[34]

In the study, perceived quiet firing and quiet quitting intentions of health workers are at a moderate level. Upon analysing the mean scores on the scale item, it was determined that the item 'My manager/supervisor has increased my workload, but no raise or increase in pay' had the highest mean score. Despite the absence of professional differences, the low number of healthcare professionals per patient in Turkey is noteworthy in terms of workload.[35] In addition, inadequacies in wage systems and distribution seem to affect the quality of work life among healthcare personnel. Although there is limited information in the relevant field in the literature, a study on the quiet quitting process similarly emphasized that the primary issue was related to the wage phenomenon, according to interviews conducted with white-collar workers in Turkey.[8] In the research conducted by Gun[21] with healthcare workers in Turkey, it was determined that the most important factors causing silent resignation were inadequacies in wages and other personal rights. In the studies of Ozcan and Ilıman Yaltagil,[22] it is emphasized that wages should be increased as a solution to prevent quiet quitting.

The results of this research revealed that the QQ and QF scale had a strongly significant negative correlation with the happiness at work scale and the person-organization fit scale. Accordingly, as the person-organization fit scale and happiness at work scale scores decreased, the QQ and QF scale scores increased. Zenger and Folkman[11] suggested that quiet quitting occurred because organizations were unable to form meaningful relationships with their employees. Research indicates that establishing a connection between employees and the organization through common goals, vision, motivation and understanding plays a key role in ensuring employee loyalty.[10] It is also emphasized that the overlap between individuals' values, norms and life philosophies and organizational values will promote employee happiness and increase organizational productivity and performance.[36]

In this study, strong correlations were detected between the QQ and QF scale and the subscales of the happiness at work scale. As the level of engagement in employees decreased, the QQ and QF scale scores increased. Engagement in work is considered the antithesis of burnout.[37] Individuals who are engaged in their work exhibit a high level of integration with their work, resulting in increased productivity and efficiency for their organization. In addition, committed employees tend to make efforts to increase team performance, even at the expense of their own interests.[38] Given the importance of having a committed workforce for organizational success,[39] it is crucial to prioritize the assessment of quiet quitting and quiet firing processes.

According to the results of this study, as healthcare workers' job satisfaction and affective organizational commitment decreased, their QQ and QF scale scores increased. When employees perceive a lack of appreciation, their commitment levels decrease, leading to a quiet quitting process in response to their employer's actions.[40] Studies on this subject emphasize the importance of job satisfaction in preventing quiet quitting.[10] A study conducted with nurses showed that increasing their satisfaction levels was necessary to reduce their quiet quitting levels.[41] The Gallup report highlighted a striking decrease in commitment and job satisfaction rates among employees belonging to Generations Y and Z.[3] Failure to effectively manage quiet quitting and quiet firing processes can hinder the development and retention of highly committed employees who have the potential to be more productive.[16] The findings of the current research indicated a negative correlation between the QQ and QF scale score and the person-organization fit scale and happiness at work scale subscale scores, suggesting that the adapted scale achieved concurrent validity.

The COVID-19 pandemic has brought about changes in working conditions and methods of conducting business. It has become difficult for workers, including nurses, to resign from their current positions and secure alternative employment. This situation has led to an increase in the rate of quiet quitting among employees.[18] In the current study, it was determined that there was no significant difference between the levels of quiet quitting and quiet firing among healthcare workers. In a previous study evaluating the level of quiet quitting among healthcare professionals, it was reported that, as a different and striking finding, the quiet quitting level of the nurses was observed to be higher.[19] Another study shows that nurses experienced higher levels of job burnout, job dissatisfaction and intention to leave than other healthcare professionals.[17] It has also been emphasized that the quiet quitting process of a member of a profession may have a gradual negative impact on their cooperation with other members of that profession.[6] Therefore, further investigation is required to reveal interprofessional differences across healthcare professionals and to establish appropriate legislation.

This study also revealed differences in the quiet quitting and quiet firing levels of healthcare professionals according to age, status of having children, marital status, region of residence, duration of institutional experience and duration of professional experience. As the duration of institutional experience increased and the duration of professional experience decreased, the QQ and QF scale scores significantly increased. Similarly, Deniz[42] found that as the duration of professional experience increased, the level of quiet quitting decreased. Work experience has been shown to be a protective factor that can reduce nurses' burnout and job dissatisfaction.[20] Galanis et al.[18] emphasized that as nurses' clinical experience increased, their intention to leave also increased, but quiet quitting remains an issue that should be particularly underscored as it may affect the intention to leave. Further investigation is needed to determine the differences in these levels and elucidate the factors contributing to these differences, such as age, status of having children, marital status, region of residence, duration of institutional experience and duration of professional experience.

4.1 | Limitations and strengths

The research reveals the validity and reliability of the quite quitting and quite firing scale among healthcare professionals working in Turkey. The research provides data that will contribute significantly to the literature on the concepts of quiet quitting and quite firing, person-organization fit and workplace happiness. The research fills an important gap in the literature. However, the research has several limitations. Research data is limited to the answers of the health professionals who participated in the research. Therefore, the research results cannot be generalized. In addition, the limitations of the research include the fact that the research is web-based and the insufficiency of research on the subject makes it difficult to compare the findings.

5 | CONCLUSIONS

Healthcare professionals represent the profession most impacted by the transformation process that was initiated by the COVID-19 pandemic. Given the global shortage of healthcare professionals, especially nurses, it is crucial to prioritize employee retention and establish conducive work environments. The initial stage of this process involves identifying and presenting the current situation. To this end, the current study performed the validity and reliability

analyses of the Turkish version of the QQ and QF scale. The research findings indicate that this scale is adequate and satisfactory in terms of distribution, measurement ability, internal consistency and model fit. It can be used to determine the quiet quitting and perceived quiet firing levels of healthcare professionals.

6 | RELEVANCE FOR CLINICAL PRACTICE

Quite quitting and quite firing negatively affect the performance of healthcare professionals and the institution. A measurement tool is needed to measure employees' perceptions of quite quitting and quite firing. In the research conducted to meet this need, it was revealed that the quite quitting and quite firing scale is a valid and reliable tool in the Turkish sample. Conducting the research among all healthcare professionals aims to reveal the differences between employees working together. In the research, the perceived quiet firing level and quiet quitting intentions of healthcare professionals are at a moderate level. It is also striking that the items with the highest item averages are related to economic factors and managerial attention. In the comparisons made for the concurrent validity of the scale, it is seen that the quite quitting and quite firing scale is highly related to person-organization harmony and workplace happiness. Institutional managers who want to ensure workplace happiness and person-organization fit should monitor the quite quitting and quite firing perception levels of healthcare professionals, especially nurses managers, who constitute the largest group numerically, and take into account the individual factors that affect them. In addition, making arrangements for economic factors and ensuring that the manager's care and support is felt by the healthcare professionals will also contribute to reducing the levels of perceived quiet firing and quiet quitting intentions.

AUTHOR CONTRIBUTIONS

Ayse Karadas and Celalettin Çevik: Conceptualization; investigation; writing—original draft; methodology; validation; writing—review and editing; formal analysis; project administration; supervision. All authors meet authorship criteria and endorsed the final article and all authors with authorship rights were listed as authors.

ACKNOWLEDGEMENTS

The authors are grateful to all the healthcare professionals for their cooperation in this study. This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Balikesir University Health Sciences Non-Interventional Research Ethics Committee permission was obtained to conduct the research (Decision Number: 2023/111).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Karadas A, Çevik C. Psychometric analysis of the quiet quitting and quiet firing scale among Turkish healthcare professionals. *J Eval Clin Pract*. 2024;1-9. doi:10.1111/jep.14136