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Work life balance and psychological wellbeing as correlates of quiet quitting among physicians

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Physicians are exposed to persistent occupational stressors, which place them at increased risk for burnout and occupational disengagement. In the post-pandemic era, "quiet quitting" has emerged as a form of occupational disengagement characterized by psychological withdrawal while maintaining formal job roles. Understanding the mechanisms underlying this phenomenon is critical for sustaining motivation and well-being in healthcare professionals. This study aimed to investigate quiet quitting as an indicator of reduced occupational engagement among physicians and to examine its associations with work–life balance and psychological well-being within the framework of occupational motivation and burnout A cross-sectional analytical study was conducted with 426 physicians between December 2025 and February 2026. Participants completed the Work–Life Balance Scale, Psychological Well-Being Scale, and Quiet Quitting Scale. Associations were analyzed using Spearman correlation, and hierarchical multiple linear regression was performed to identify independent predictors of quiet quitting. Quiet quitting showed a moderate negative correlation with psychological well-being ($r = -0.379$, $p < 0.001$) and positive work-to-life spillover ($r = -0.424$, $p < 0.001$), and a positive correlation with negative life-to-work spillover ($r = 0.365$, $p < 0.001$). In regression analyses, psychological well-being ($\beta = -0.176$, $p < 0.001$) and positive work-to-life spillover ($\beta = -0.281$, $p < 0.001$) emerged as significant protective factors against quiet quitting. Additionally, medico-legal experiences and consideration of leaving the profession were associated with increased disengagement. Quiet quitting may represent a clinically relevant manifestation of reduced motivation and occupational disengagement among physicians. Our findings highlight the need for integrated interventions targeting both structural work conditions and individual psychological resources to mitigate disengagement and support sustainable workforce well-being in healthcare systems.

Keywords Physicians, Quiet quitting, Work–life balance, Psychological well-being, Occupational disengagement, Motivation

The medical profession is characterized by high levels of cognitive demand, time pressure, and emotional labor, making physicians particularly vulnerable to psychosocial strain. Increasing demands on healthcare systems, long and irregular working hours, and structural challenges in service delivery have placed substantial pressure on physicians' mental health and occupational functioning[1]. Recent evidence indicates that burnout, depression, and anxiety symptoms are highly prevalent among physicians and medical trainees worldwide[2]. The COVID-19 pandemic has further intensified these challenges by exposing healthcare professionals to unprecedented occupational stressors, thereby amplifying concerns regarding psychological well-being in the medical workforce[3,4].

Physicians' psychological well-being is not only essential for individual mental health but also represents a critical determinant of healthcare quality, patient safety, and workforce sustainability. Lower levels of well-being among healthcare professionals have been associated with increased burnout, reduced job satisfaction, and higher turnover intentions, whereas higher well-being has been linked to improved job performance and better patient outcomes[5,6]. Accordingly, understanding the psychosocial factors associated with physicians' well-being has become a key research priority in efforts to strengthen healthcare systems and maintain service quality.

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In recent years, the concept of "quiet quitting" has gained increasing attention in the work and organizational psychology literature. Quiet quitting refers to a state in which employees remain in their positions but psychologically disengage from their work, performing only the minimum role requirements and withdrawing their cognitive and emotional investment[7].This phenomenon has been suggested to emerge in response to increasing workload, occupational burnout, and deteriorating work–life balance, particularly in the aftermath of the COVID-19 pandemic[8,9]. In healthcare settings, where high levels of responsibility, vigilance, and emotional involvement are essential, quiet quitting may represent not merely an individual coping strategy but also a form of professional withdrawal that could negatively influence patient safety, team functioning, and service quality[10].

Work–life balance has been identified as a central work-related factor influencing psychological well-being among physicians. The spillover of professional demands into personal life may limit opportunities for recovery and increase chronic stress burden, ultimately undermining psychological functioning[11,12]. Impaired work–life balance has also been associated with reduced professional motivation, lower job satisfaction, and decreased intention to remain in the profession, highlighting its relevance for the long-term sustainability of the healthcare workforce[13,14]. In this context, work–life balance can be conceptualized as an important occupational resource that shapes physicians' psychological well-being and occupational functioning.

Theoretical perspectives on occupational stress, particularly the Job Demands–Resources model, propose that employees' well-being and work-related attitudes are shaped by the balance between job demands and available personal or organizational resources[15]. In medical practice, exposure to high job demands such as medico-legal pressures, challenging patient interactions and other occupational stressors may increase the likelihood of psychological withdrawal behaviors. Conversely, psychosocial resources such as psychological well-being and a balanced integration of work and personal life may buffer against disengagement and adverse occupational outcomes[16,17]. Within this framework, the variables included in the present study were operationalized according to the JD-R model. Negative work–life spillover, negative life–to–work spillover, medico-legal exposure, and consideration of leaving the profession were considered as job demands, reflecting sources of occupational strain. In contrast, psychological well-being and positive work–life spillover were conceptualized as job and personal resources that may protect against occupational disengagement. Accordingly, quiet quitting was defined as the primary outcome variable, representing reduced occupational engagement and work-related motivation.

Although previous research has extensively examined burnout, job satisfaction, and turnover intentions among physicians, empirical evidence addressing quiet quitting within the medical profession remains limited. In particular, the combined roles of psychological well-being and work–life balance in shaping physicians' tendencies toward quiet quitting have not been adequately explored. Considering that reduced occupational disengagement may have far-reaching consequences for both individual physicians and healthcare systems, investigating these relationships is of substantial importance.

Therefore, the aim of the present study was to examine the association between work–life balance and psychological well-being and the tendency toward quiet quitting among physicians, and to identify key factors contributing to this relationship. Accordingly, quiet quitting was defined as the dependent variable reflecting occupational disengagement, while psychological well-being and work–life balance dimensions were operationalized as independent variables. The findings are expected to inform the development of preventive and supportive interventions aimed at reducing professional withdrawal behaviors and enhancing physician well-being, ultimately contributing to the sustainability and effectiveness of healthcare services.

Based on the Job Demands–Resources (JD-R) framework and previous literature, it was hypothesized that psychological well-being would be negatively associated with quiet quitting among physicians, whereas positive work–life spillover would also show a negative association. In contrast, negative work–life spillover dimensions were expected to be positively associated with quiet quitting. Additionally, medico-legal exposure and intention to leave the profession were expected to be positively associated with quiet quitting, while psychological well-being and positive work–life spillover were expected to act as protective predictors of quiet quitting.

Materials and methods

Ethical approval

The study was approved by the Clinical Research Ethics Committee of University of Health Sciences Bursa Yuksek Ihtisas Training and Research Hospital (Protocol No: 2024-TBEK-2025/11–12). All procedures were conducted in accordance with the principles of the Declaration of Helsinki. Participation was voluntary and informed consent was obtained electronically from all participants prior to data collection.

Study design and participants

This study was designed as a cross-sectional analytical investigation. The target population consisted of physicians actively working in healthcare institutions in Türkiye. Data were collected between 15 December 2025 and 15 February 2026 through an online survey. Participants were recruited using a snowball sampling strategy through professional communication networks and social media groups involving physicians.

A total of 426 physicians who met the inclusion criteria were included in the final sample. Eligibility criteria included active employment as a physician, age between 24 and 70 years, and provision of informed consent. Participants were excluded if they had a neurological condition that could affect the completion or interpretation of self-report assessments (e.g., dementia or other organic neurological disorders), a diagnosis of schizophrenia or another psychotic disorder, or if they declined participation. Eligibility was determined based on self-reported information provided by participants through the online survey.The survey was administered online, and the platform was configured to accept only fully completed questionnaires. Therefore, no cases were excluded due to missing data.

Measures

Sociodemographic information form

This form was developed by the researchers to obtain information on participants' age, gender, marital status, type of employing institution, professional seniority, frequency of night shifts, history of medico-legal processes, presence of psychiatric illness, intention to leave the profession, and perceptions regarding patient safety.

Work–life balance scale

The Work–Life Balance Scale was originally developed by Fisher et al. and adapted into Turkish by Ekinci and Sabancı[18,19]. The scale consists of 17 items rated on a five-point Likert scale and includes four subdimensions: negative work-to-life spillover, negative life-to-work spillover, positive work-to-life spillover, and positive life-to-work spillover. Higher scores indicate greater perceived spillover in the respective dimension. In the present study, internal consistency reliability was evaluated separately for each subdimension. Cronbach's alpha coefficients were 0.917 for negative work-to-life spillover (5 items), 0.842 for negative life-to-work spillover (6 items), 0.827 for positive work-to-life spillover (3 items), and 0.828 for positive life-to-work spillover (3 items), indicating good to excellent reliability across all subdimensions. McDonald's omega values were similarly high (ω = 0.939, 0.895, 0.897, and 0.898, respectively), confirming the adequacy of the factorial structure of each subdimension.

Psychological well-being scale

Psychological well-being was assessed using the eight-item scale developed by Diener et al., with Turkish validity and reliability established by Telef[20,21]. Items are rated on a seven-point Likert scale, and higher total scores indicate better psychological well-being. The scale evaluates key dimensions of psychological well-being, including purpose and meaning in life, supportive social relationships, engagement in daily activities, contribution to others' well-being, perceived competence, self-worth, optimism about the future, and perceived social respect. In the present sample, the scale demonstrated good internal consistency (Cronbach's α = 0.830; McDonald's ω = 0.875). Corrected item-total correlations ranged from 0.44 to 0.67, and no item deletion improved the overall alpha, supporting the retention of all eight items.

Quiet quitting scale

Quiet quitting tendencies were measured using the Quiet Quitting Scale developed by Anand et al. and validated in Turkish by Yıldız et al.[22,23]. This unidimensional instrument comprises seven items rated on a five-point Likert scale and evaluates behavioral and psychological disengagement from work. Higher scores reflect a greater tendency toward quiet quitting. The scale assesses employees' behavioral and psychological disengagement from work, including tendencies to perform only the minimum level of work required, reluctance to exert effort beyond formal job responsibilities, reduced work motivation, limited participation in organizational activities, perceived lack of learning and development opportunities, diminished sense of meaning derived from work, and feelings of insufficient recognition by supervisors. Example items include "I usually avoid working more unless there is additional compensation" and "I feel that learning and development opportunities are lacking in my institution. In the current study, the scale showed acceptable to good internal consistency (Cronbach's α = 0.738; McDonald's ω = 0.816). Corrected item-total correlations ranged from 0.32 to 0.57, and alpha values upon item deletion ranged from 0.679 to 0.736, indicating that all items contributed adequately to the overall scale.

Statistical analysis

Statistical analyses were performed using IBM SPSS Statistics version 22.0. Continuous variables were presented as mean and standard deviation, while categorical variables were summarized as frequencies and percentages. The distributional properties of all continuous variables were examined using the Shapiro–Wilk test, along with skewness and kurtosis indices. Significant deviations from normality were observed for most study variables ($p < 0.001$), with the exception of the Quiet Quitting Scale total score ($W = 0.993$, $p = 0.057$). Given that normality assumptions were not fully satisfied across variables, non-parametric statistical methods were employed for group comparisons and correlation analyses.

Group comparisons for continuous variables were conducted using the Mann–Whitney U test, and associations between categorical variables were evaluated using the chi-square test. Relationships between psychological well-being, quiet quitting, and work–life balance subdimensions were examined using Spearman rank correlation analysis. Data visualization and graphical representations were generated using Python programming language in the Google Colab cloud-based computational environment.

To identify factors associated with quiet quitting among physicians, a three-step hierarchical multiple linear regression analysis was performed. In the first step, sociodemographic characteristics were entered as control variables. In the second step, psychological variables, including psychological well-being and psychiatric characteristics, were added. In the third step, work–life balance subdimensions and work-related variables were included in the model. Given the adequate sample size and examination of regression residuals indicating acceptable model assumptions, the use of parametric regression modelling was considered appropriate. Multicollinearity was assessed using variance inflation factor and tolerance statistics, and independence of residuals was evaluated using the Durbin–Watson statistic. Model fit was interpreted using the coefficient of determination, adjusted coefficient of determination, and F statistics.

Given the use of snowball sampling, which does not permit prospective control over the number of respondents, a formal a priori power analysis could not be conducted prior to data collection. The adequacy of the sample size for multiple regression analyses was subsequently evaluated through a post hoc power analysis. Based on the coefficient of determination obtained in the final regression model ($R^2 = 0.346$), the calculated effect size was high ($f^2 = 0.53$). Considering the total sample size of 426 participants and the number of predictors

included in the model, the statistical power of the analyses was found to be greater than 0.99, indicating that the study was adequately powered for the analyses conducted. A p value of less than 0.05 was considered statistically significant in all analyses.

Results

A total of 426 physicians were included in the study. Of the participants, 36.4% ($n = 155$) were male and 63.6% ($n = 271$) were female. The mean age of the participants was 37.27 years (SD = 8.97; range: 23–65 years). The sociodemographic, professional, and clinical characteristics of the participants are presented in Table 1.

Descriptive statistics for all study variables are presented in Table 2. This table provides an overview of the distribution of key study measures used in subsequent analyses.

The distribution of physicians' scores on the Work–Life Balance Scale subdimensions is shown in Table 3. Mean scores were 18.6 ± 4.5 (min: 7, max: 25) for negative work-to-life spillover, 13.2 ± 4.6 (min: 6, max: 30) for negative life-to-work spillover, and 7.4 ± 2.6 (min: 3, max: 15) for positive work-to-life spillover. The proportion of "agree" or "strongly agree" responses was relatively low for the positive work-to-life spillover dimension. In contrast, the mean score for positive life-to-work spillover was 9.8 ± 2.5 (min: 3, max: 15), indicating comparatively higher levels of positive responses in this subdimension.

The mean total score on the Psychological Well-Being Scale was 40.7 ± 7.1, and the distribution of responses to individual items is presented in Fig. 1. The distribution of responses to individual scale items is presented in Fig. 1 to illustrate the variability in endorsement patterns across items. Notably, Item 7 ("I am optimistic about my future") received comparatively lower ratings, with a higher proportion of physicians selecting neutral or negative response options, suggesting that optimism about the future was the least endorsed dimension of psychological well-being in this sample.

The mean total Quiet Quitting Scale score was 22.5 ± 5.3 (min: 8, max: 35). The distribution of responses to scale items is provided in Fig. 2. The figure suggests that perceptions of insufficient professional development opportunities and inadequate managerial recognition were among the most frequently endorsed quiet quitting indicators. A total of 64.1% ($n = 273$) of physicians agreed or strongly agreed with the statement "I feel a lack of learning and development opportunities in my institution." Regarding meaning at work, 46.7% ($n = 199$)

Variable	*n*	%	Variable	*n*	%
Gender			Marital status		
Male	155	36.4	Single	130	30.5
Female	271	63.6	Married	296	69.5
Parental status			Department		
Yes	218	51.2	General practitioner	42	9.8
No	208	48.8	Basic Medical Sciences	15	3.5
Professional position			Internal Medical Sciences	254	59.6
General practitioner	42	9.9	Surgical Medical Sciences	115	27.0
Resident physician (Assistant)	117	27.5	Frequency of night shifts		
Specialist physician	201	47.2	1–3 per month	114	26.8
Subspecialist physician	26	6.1	4–6 per month	74	17.4
Faculty member	40	9.4	7 or more per month	47	11.0
Type of employing institution			Does not work night shifts	191	44.8
Public hospital	85	20.0	Formal Response to Patient Complaint		
University hospital	56	13.1	Yes	261	61.3
Training and research hospital	196	46.0	No	165	38.7
Private hospital / Private practice	28	6.6	History of medico-legal processes		
Other (e.g., forensic medicine institute, public health center, etc.)	61	14.3	Yes	139	32.6
Intention to leave the profession			No	287	67.4
Never	105	24.6	Considering non-medical employment		
Rarely	122	28.6	Never	82	19.2
Sometimes	126	29.6	Rarely	125	29.3
Often	73	17.1	Sometimes	123	28.9
Perceived risk of medical errors due to workload			Often	96	22.5
Never	28	6.6			
Rarely	103	24.2			
Sometimes	149	35.0			
Often	146	34.3			

Table 1. Sociodemographic, occupational, and clinical characteristics of the participants. n: number; %: percentage.

Variable	*N*	Mean	SD	Median	Min	Max	Skewness	Kurtosis	SW W	*p*
Age	426	37.27	8.97	36.00	23	65	0.879	0.310	0.936	< 0.001
Psychological Well-Being	426	40.75	7.17	42.00	12	56	−0.878	0.853	0.950	< 0.001
Quiet Quitting	426	22.60	5.32	22.00	8	35	−0.036	−0.302	0.993	0.057
WLB – Neg. Work-to-Life Spillover	426	18.67	4.57	20.00	7	25	−0.379	−0.807	0.946	< 0.001
WLB – Neg. Life-to-Work Spillover	426	13.26	4.63	13.00	6	30	0.920	1.104	0.939	< 0.001
WLB – Pos. Work-to-Life Spillover	426	7.45	2.64	7.00	3	15	0.283	−0.555	0.963	< 0.001
WLB – Pos. Life-to-Work Spillover	426	9.86	2.59	10.00	3	15	−0.359	−0.369	0.957	< 0.001

Table 2. Descriptive Statistics and Normality Test Results for Study Variables. WLB = Work–Life Balance; Neg. = Negative; Pos. = Positive; SD = Standard Deviation; SW W = Shapiro–Wilk statistic. Skewness and kurtosis values within the range of ± 2 are generally considered acceptable for distribution normality. The Quiet Quitting scale was the only variable with a non-significant Shapiro–Wilk test ($p = 0.057$), suggesting an approximately normal distribution; all other variables showed statistically significant deviations from normality, consistent with the use of non-parametric statistical methods.

Item	Strongly Disagree *n* (%)	Disagree *n* (%)	Neutral *n* (%)	Agree *n* (%)	Strongly Agree *n* (%)
Negative Work-to-Life Spillover|Total Score: 18.67 ± 4.57; range: 7–25					
1	4 (0.9%)	28 (6.6%)	41 (9.6%)	202 (47.4%)	151 (35.4%)
2	4 (0.9%)	66 (15.5%)	61 (14.3%)	174 (40.8%)	121 (28.4%)
3	5 (1.2%)	79 (18.5%)	61 (14.3%)	177 (41.5%)	104 (24.4%)
4	10 (2.3%)	116 (27.2%)	67 (15.7%)	142 (33.3%)	91 (21.4%)
5	5 (1.2%)	86 (20.2%)	68 (16.0%)	168 (39.4%)	99 (23.2%)
Negative Life-to-Work Spillover|Total Score: 13.26 ± 4.63; range: 6–30					
6	94 (22.1%)	175 (41.1%)	45 (10.6%)	74 (17.4%)	38 (8.9%)
7	120 (28.2%)	221 (51.9%)	36 (8.5%)	37 (8.7%)	12 (2.8%)
8	130 (30.5%)	212 (49.8%)	32 (7.5%)	42 (9.9%)	10 (2.3%)
9	138 (32.4%)	215 (50.5%)	34 (8.0%)	33 (7.7%)	6 (1.4%)
10	42 (9.9%)	164 (38.5%)	83 (19.5%)	116 (27.2%)	21 (4.9%)
11	143 (33.6%)	216 (50.7%)	33 (7.7%)	26 (6.1%)	8 (1.9%)
Positive Work-to-Life Spillover|Total Score: 7.45 ± 2.64; range: 3–15					
12	51 (12.0%)	162 (38.0%)	107 (25.1%)	92 (21.6%)	14 (3.3%)
13	88 (20.7%)	162 (38.0%)	100 (23.5%)	72 (16.9%)	4 (0.9%)
14	73 (17.1%)	192 (45.1%)	88 (20.7%)	66 (15.5%)	7 (1.6%)
Positive Life-to-Work Spillover|Total Score: 9.86 ± 2.59; range: 3–15					
15	14 (3.3%)	112 (26.3%)	120 (28.2%)	154 (36.2%)	26 (6.1%)
16	13 (3.1%)	71 (16.7%)	87 (20.4%)	220 (51.6%)	35 (8.2%)
17	17 (4.0%)	104 (24.4%)	97 (22.8%)	172 (40.4%)	36 (8.5%)

Table 3. Distribution of Physicians' Responses to the Work–Life Balance Scale Items by Subdimension. Items 1–5 belong to the Negative Work-to-Life Spillover subdimension; Items 6–11 to Negative Life-to-Work Spillover; Items 12–14 to Positive Work-to-Life Spillover; Items 15–17 to Positive Life-to-Work Spillover. All items are rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). Higher scores indicate greater perceived spillover in the respective subdimension. n = number of participants; % = percentage.

reported agreement or strong agreement with the statement "I feel a lack of meaning in my work." In addition, 48.3% ($n = 206$) of participants agreed or strongly agreed that "I feel that my supervisor does not care about me."

Further examination of items indicated that 60.1% ($n = 256$) of physicians reported a lack of enthusiasm and passion for working beyond minimum requirements, while 58.2% ($n = 248$) reported unwillingness to participate in institutional meetings. Descriptive analysis of item-level responses on the Quiet Quitting Scale indicated that a considerable proportion of physicians reported limited opportunities for professional development and perceived insufficient recognition from supervisors.

No significant differences were observed in quiet quitting scores according to gender ($z = -0.041$, $p = 0.967$) or marital status ($z = 0.610$, $p = 0.542$). Physicians with a history of psychiatric diagnosis had significantly higher quiet quitting levels compared with those without such a diagnosis ($z = -3.217$, $p = 0.001$). Similarly, physicians who had experienced medico-legal litigation with patients had significantly higher quiet quitting scores than those without such experience ($z = -3.220$, $p = 0.001$). Physicians who had previously been required to provide formal written responses to patient complaints also demonstrated significantly higher quiet quitting scores

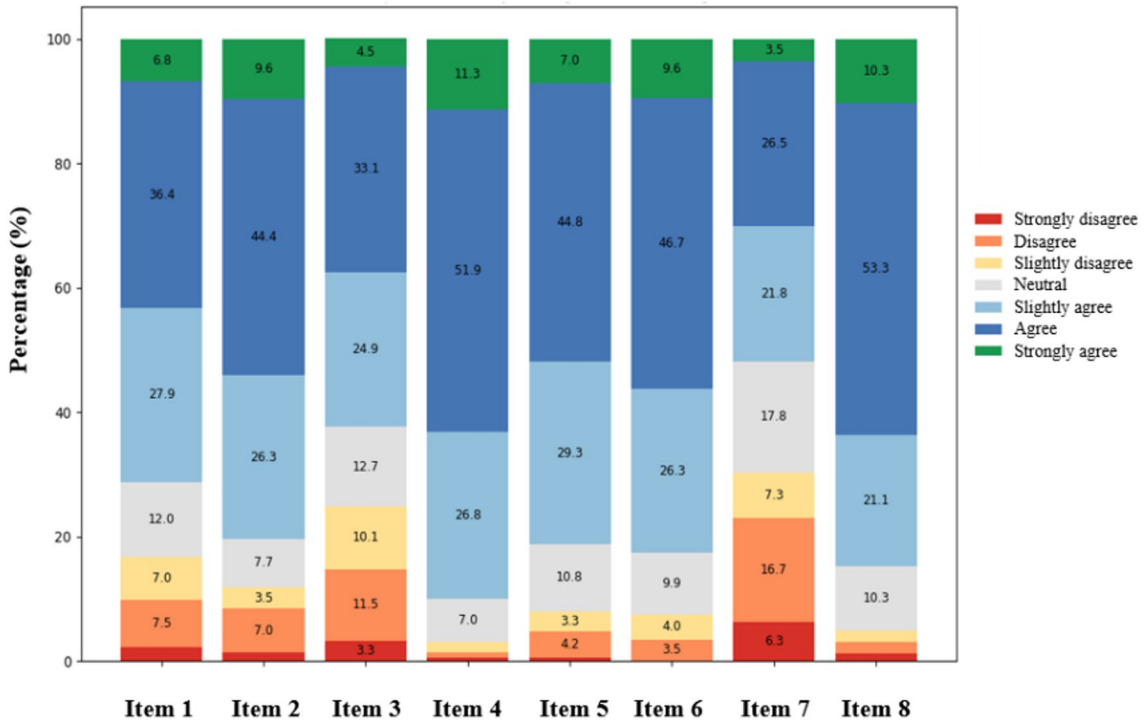


Fig. 1. Distribution of Physicians' Responses to the Psychological Well-Being Scale Items*. *Item statements (Psychological Well-Being Scale): (1) I lead a purposeful and meaningful life; (2) My social relationships are supportive and satisfying; (3) I am engaged and interested in my daily activities; (4) I actively contribute to the happiness and well-being of others; (5) I am competent and capable in important activities; (6) I am a good person and live a good life; (7) I am optimistic about my future; (8) People respect me.

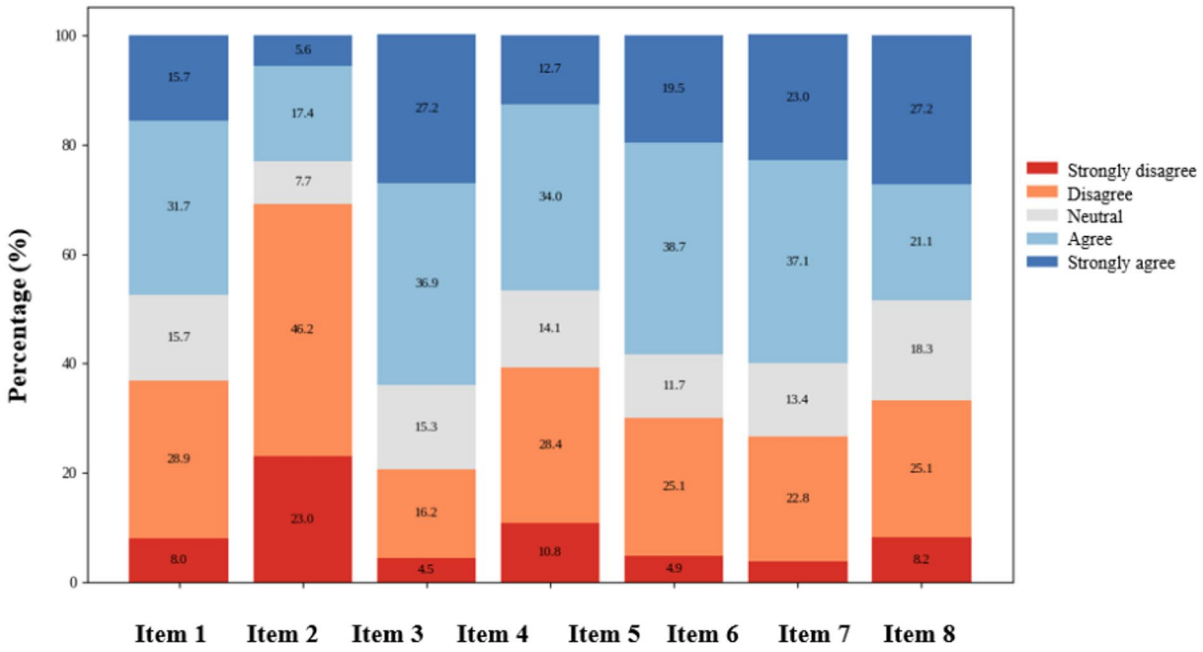


Fig. 2. Distribution of Physicians' Responses to the Quiet Quitting Scale Items*. *Item statements (Quiet Quitting Scale): (1) I usually avoid working extra hours if there is no additional payment; (2) I perform only the minimum level of work required to maintain my position; (3) I feel that there is a lack of opportunities for learning and professional development in my institution; (4) I feel a lack of meaning in the work I do; (5) I am not willing to participate in meetings at my institution; (6) I feel a lack of passion and motivation to work beyond what is necessary; (7) I feel that my manager does not value me.

(z = – 2.978, $p = 0.003$). Comparisons of quiet quitting scores according to sociodemographic and occupational characteristics are presented in Table 4.

Relationships between psychological well-being, quiet quitting, and work–life balance subdimensions were examined using Spearman correlation analysis, and the results are shown in Table 5. No statistically significant correlation was observed between age and quiet quitting scores (Spearman's ρ = 0.092, $p = 0.058$). A moderate negative correlation was found between psychological well-being and quiet quitting ($r = – 0.379$, $p < 0.001$).

Psychological well-being was negatively correlated with negative life-to-work spillover ($r = – 0.240$, $p < 0.001$) and negative work-to-life spillover ($r = – 0.407$, $p < 0.001$). In contrast, psychological well-being showed positive

Variable	Group	*n* (%)	Mean ± SD	Test (statistic)	*p*
Gender	Male	155 (36.4%)	22.49 ± 5.63	z=-0.041	0.967
	Female	271 (63.6%)	22.66 ± 5.15		
Marital status	Single	130 (30.5%)	22.28 ± 5.23	z = 0.610	0.542
	Married	296 (69.5%)	22.74 ± 5.37		
Parental status	Yes	218 (51.2%)	22.87 ± 5.27	z=-0.905	0.366
	No	208 (48.8%)	22.31 ± 5.38		
Professional position	General practitioner	42 (9.9%)	24.40 ± 4.76	H = 38.499	**< 0.001***
	Assistant	117 (27.5%)	20.65 ± 5.18		
	Specialist physician	201 (47.2%)	23.88 ± 5.10		
	Subspecialist physician	26 (6.1%)	21.27 ± 5.17		
	Faculty Member	40 (9.4%)	20.85 ± 5.20		
Department	General practitioner	44 (10.3%)	24.32 ± 4.66	H = 7.157	0.067
	Basic Medical Sciences	13 (3.1%)	22.00 ± 4.90		
	Internal Medical Sciences	254 (59.6%)	22.48 ± 5.39		
	Surgical Medical Sciences	115 (27.0%)	22.26 ± 5.39		
Frequency of night shifts	1–3	114 (26.8%)	22.42 ± 5.14	H = 4.372	0.224
	4–6	74 (17.4%)	21.92 ± 5.46		
	≥7	47 (11.0%)	23.87 ± 5.08		
	None	191 (44.8%)	22.65 ± 5.42		
Type of employing institution	Public hospital	85 (20.0%)	24.61 ± 5.45	H = 31.957	**< 0.001****
	University hospital	56 (13.1%)	19.80 ± 4.93		
	Training and research hospital	196 (46.0%)	22.40 ± 5.23		
	Private hospital	19 (4.5%)	22.68 ± 5.92		
	Private practice	9 (2.1%)	19.11 ± 3.89		
	Other	61 (14.3%)	23.49 ± 4.43		
Presence of psychiatric illness	Yes	88 (20.7%)	24.09 ± 5.25	z=-3.217	**0.001**
	No	338 (79.3%)	22.21 ± 5.28		
Using psychotropic medication	Yes	87 (20.4%)	23.46 ± 5.18	z=-2.009	**0.045**
	No	339 (79.6%)	22.38 ± 5.35		
Formal Response to Patient Complaint	Yes	261 (61.3%)	23.21 ± 5.41	z=-2.978	**0.003**
	No	165 (38.7%)	21.63 ± 5.05		
History of medico-legal processes	Yes	139 (32.6%)	23.83 ± 5.47	z=-3.220	**0.001**
	No	287 (67.4%)	22.00 ± 5.16		
Considering non-medical employment	Never	82 (19.2%)	20.56 ± 5.72	H = 37.275	**< 0.001**†
	Rarely	125 (29.3%)	21.61 ± 5.43		
	Sometimes	123 (28.9%)	23.03 ± 4.44		
	Often	96 (22.5%)	25.07 ± 4.87		

Table 4. Comparison of Quiet Quitting Scores According to Physicians' Sociodemographic and Occupational Characteristics. n: number of participants; %: percentage; for comparisons between two groups, the Mann–Whitney U test was used, and for comparisons involving more than two groups, the Kruskal–Wallis H test was applied. A p-value < 0.05 was considered statistically significant. *In the Bonferroni-corrected post hoc analysis, significant differences were observed between faculty members and both specialists and general practitioners, as well as between residents and both specialists and general practitioners ($p < 0.05$). ** In the Bonferroni-corrected post hoc analysis, significant differences were observed in the comparisons between private practice and state hospital, university hospital and training and research hospital, university hospital and state hospital, and training and research hospital and state hospital ($p < 0.05$). † In the Bonferroni-corrected post hoc analysis, significant differences were found between the "never–sometimes" "never–often" and "rarely–often" groups ($p < 0.05$).

Variable	Psychological Well-Being	Quiet Quitting	Negative Life-to-Work Spillover	Negative Work-to-Life Spillover	Positive Life-to-Work Spillover	Positive Work-to-Life Spillover
Psychological Well-Being	1.000	-0.379**	-0.240**	-0.407**	0.374**	0.332**
Quiet Quitting	-0.379**	1.000	0.120*	0.365**	-0.120*	-0.424**
Negative Life-to-Work Spillover	-0.240**	0.120*	1.000	0.179**	-0.291**	0.060
Negative Work-to-Life Spillover	-0.407**	0.365**	0.179**	1.000	-0.209**	-0.448**
Positive Life-to-Work Spillover	0.374**	-0.120*	-0.291**	-0.209**	1.000	0.172**
Positive Work-to-Life Spillover	0.332**	-0.424**	0.060	-0.448**	0.172**	1.000

Table 5. Spearman Correlation Coefficients between Psychological Well-Being, Quiet Quitting, and Work–Life Balance Subdimensions. Spearman correlation coefficient (ρ)* $p < 0.05$; ** $p < 0.01$.

Model	R^2	ΔR^2	F (df)	*p*
Model 1	0.097	-	4.45 (10, 415)	**< 0.001**
Model 2	0.211	0.114	8.45 (13, 412)	**< 0.001**
Model 3	0.346	0.135	10.71 (20, 405)	**< 0.001**
Variable	**Model 1 β**	**Model 2 β**	**Model 3 β**	**VIF (Model 3)**
Gender	− 0.029	− 0.011	− 0.003	1.16
Marital status	− 0.003	0.023	0.010	1.51
Parental status	0.049	0.027	0.043	1.75
Professional position	ns	ns	ns	1.68
Department	ns	ns	ns	1.49
Psychological Well-Being	-	**− 0.322*****	**− 0.176*****	1.52
Presence of psychiatric illness	-	− 0.106	− 0.098	1.85
Using psychotropic medication	-	0.050	0.041	1.85
Formal Response to Patient Complaint	-	-	− 0.013	1.48
History of medico-legal processes	-	-	**− 0.090***	1.27
Considering non-medical employment	-	-	**0.114***	1.19
Negative Life-to-Work Spillover	-	-	**0.094***	1.27
Negative Work-to-Life Spillover	-	-	0.091	1.64
Positive Life-to-Work Spillover	-	-	0.061	1.38
Positive Work-to-Life Spillover	-	-	**− 0.281*****	1.54

Table 6. Hierarchical Regression Analysis of Factors Predicting Quiet Quitting. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; Durbin–Watson = 0.94.

correlations with positive life-to-work spillover ($r = 0.374$, $p < 0.001$) and positive work-to-life spillover ($r = 0.332$, $p < 0.001$).

Quiet quitting was moderately positively correlated with negative work-to-life spillover ($r = 0.365$, $p < 0.001$) and moderately negatively correlated with positive work-to-life spillover ($r = -0.424$, $p < 0.001$). Weak positive and negative correlations were observed between quiet quitting and negative life-to-work spillover ($r = 0.120$, $p = 0.013$) and positive life-to-work spillover ($r = -0.120$, $p = 0.013$), respectively.

A three-step hierarchical multiple regression analysis was conducted to identify predictors of quiet quitting among physicians (Table 6**).** Prior to analysis, multicollinearity assumptions were evaluated. Variance inflation factor values ranged between 1.16 and 1.85, and tolerance values ranged between 0.54 and 0.86, indicating no significant multicollinearity problem.

In the first step, sociodemographic variables (gender, marital status, parental status, professional position, and department) were entered into the model. Model 1 was statistically significant ($F(10, 415) = 4.45$, $p < 0.001$) and explained 9.7% of the variance in quiet quitting scores ($R^2 = 0.097$, adjusted $R^2 = 0.075$).

In the second step, psychological variables (psychological well-being, psychiatric diagnosis, and psychiatric medication use) were added. The explanatory power of the model increased significantly ($\Delta R^2 = 0.114$, F change $(3, 412) = 19.80$, $p < 0.001$). Model 2 explained 21.1% of the total variance ($R^2 = 0.211$, adjusted $R^2 = 0.186$). Psychological well-being emerged as a significant negative predictor of quiet quitting ($\beta = -0.322$, $p < 0.001$).

In the third step, work–life balance subdimensions and additional work-related variables were included. The final model was statistically significant ($F(20, 405) = 10.71$, $p < 0.001$) and explained 34.6% of the variance in quiet quitting scores ($R^2 = 0.346$, adjusted $R^2 = 0.314$). In the final model, psychological well-being ($\beta = -0.176$, $t = -3.55$, $p < 0.001$), history of medico-legal litigation with patients ($\beta = -0.090$, $t = -1.98$, $p = 0.049$), considering employment outside the medical profession ($\beta = 0.114$, $t = 2.60$, $p = 0.010$), negative life-to-work spillover ($\beta = 0.094$, $t = 2.08$, $p = 0.038$), and positive work-to-life spillover ($\beta = -0.281$, $t = -5.64$, $p < 0.001$) were

identified as significant predictors. Positive work-to-life spillover emerged as the strongest predictor of quiet quitting. Psychological well-being has remained an independent and significant protective factor even after controlling work-related variables.

Discussion

This study examined the relationships between work–life balance, psychological well-being, and quiet quitting tendencies among physicians. The most prominent finding of the present study was that positive work-to-life spillover emerged as the strongest independent predictor of quiet quitting, even after controlling for psychological and work-related variables. In addition, psychological well-being remained a significant protective factor, highlighting the importance of both individual psychological resources and work–life interface dynamics in shaping physicians' occupational functioning.

Approximately one-fifth of the participating physicians reported having a psychiatric disorder and using psychotropic medication. This finding is consistent with previous literature indicating that depression, anxiety, and other mental health problems are relatively prevalent among physicians and medical trainees[2]. Moreover, a substantial proportion of participants reported perceiving an increased risk of medical errors due to high occupational demands and having been required to provide formal written responses to patient complaints. These findings align with studies demonstrating that high job demands and burnout may negatively influence patient safety and clinical performance[24]. High occupational demands have also been associated with increased turnover intentions among healthcare professionals. In line with these observations, nearly half of the physicians in the present study reported considering employment outside the medical profession, although only a smaller proportion actively contemplated resignation. Similar rates of intention to leave clinical positions have been reported in European multicentre studies[6], suggesting that psychological withdrawal behaviours may precede overt career transitions.

Our findings also revealed a marked asymmetry in physicians' work–life balance perceptions. A large majority reported feeling too exhausted after work to engage in personal activities, indicating a substantial spillover of occupational demands into private life. Previous research suggests that long working hours and high job demands may impair recovery processes and increase work–life conflict[25]. In contrast, more than half of the participants indicated that their personal lives contributed positively to their work performance, suggesting that family and social resources may play a buffering role against occupational stress[26]. The relatively lower perception of negative life-to-work spillover may reflect physicians' strong professional commitment and their tendency to suppress personal difficulties in clinical contexts. An additional noteworthy finding of the present study was the asymmetric relationship between work–life spillover dimensions and quiet quitting. Specifically, quiet quitting was more strongly associated with work-to-life spillover compared to life-to-work spillover, suggesting that occupational experiences exert a more pronounced influence on disengagement behaviors than the reverse direction. This pattern may reflect the predominance of work-related demands and organizational factors in shaping physicians' psychological withdrawal. In contrast, the weaker associations observed for life-to-work spillover suggest that personal life factors may play a more limited role in explaining disengagement in this professional group. Within the JD-R framework, these findings highlight the stronger role of job demands and work-related strain processes in predicting withdrawal behaviors compared to personal resource spillover effects. Practically, these findings suggest that strategies aimed at reducing quiet quitting among physicians should primarily focus on improving organizational conditions and enhancing positive work experiences rather than solely targeting individual-level factors.

Although overall psychological well-being levels were relatively high, responses indicated comparatively lower optimism regarding the future. This interpretation is based on item-level analysis of the Psychological Well-Being Scale, where the optimism about the future item showed comparatively lower scores than other dimensions of well-being. Physicians' perceptions of leading meaningful lives and contributing to others' well-being appear to constitute important sources of psychological resilience. These findings are consistent with studies highlighting the protective role of professional meaning and purpose against burnout and emotional exhaustion[27]. However, reduced optimism about the future may signal concerns regarding the sustainability of current working conditions, potentially influenced by structural challenges in healthcare systems, increasing occupational demands, and medico-legal pressures.

At the item level, descriptive findings indicated that a considerable proportion of physicians reported limited opportunities for professional development and perceived insufficient recognition from supervisors. This suggests that quiet quitting may not solely reflect individual motivational deficits but may also be shaped by organizational and managerial factors. Previous literature indicates that perceived lack of appreciation and restricted career development opportunities may reduce organizational commitment and willingness to engage in discretionary effort[28,29]. Notably, despite such challenges, many physicians in the present study reported maintaining performance levels above the minimum required, implying that improvements in managerial support and professional development opportunities may substantially enhance occupational functioning.

Another important finding was the higher quiet quitting tendency among physicians with current psychiatric conditions. Mental health problems such as depression, anxiety, and post-traumatic stress symptoms have been widely reported among healthcare workers and have been associated with reduced occupational functioning and increased withdrawal behaviours[9]. Interestingly, although quiet quitting scores were elevated in some groups, relatively few physicians reported actively considering resignation. This pattern may indicate that physicians adopt quiet quitting as a functional coping strategy within the Job Demands–Resources (JD-R) framework, allowing them to preserve their professional roles while psychologically disengaging from excessive job demands. Such behavioral withdrawal may serve as a protective mechanism to maintain occupational continuity under sustained job strain, rather than reflecting a loss of professional commitment. From this perspective, quiet quitting can be interpreted as a form of adaptive disengagement aimed at reducing emotional and cognitive

overload, thereby helping to prevent more severe outcomes such as burnout or turnover. These findings have important implications for physician well-being and workforce retention. Although quiet quitting may function as an adaptive coping strategy that enables physicians to manage excessive job demands, it may also be associated with reduced discretionary effort, which could negatively affect long-term engagement and organizational functioning. Therefore, interventions should not be limited to individual resilience-focused approaches but should also prioritize improving organizational working conditions and enhancing positive work experiences in order to support sustainable physician well-being and workforce retention.

Exposure to medico-legal complaints or litigation was also associated with higher quiet quitting levels. Complaint procedures may generate significant psychological distress, professional dissatisfaction, and reduced trust in the clinical environment[30]. When such experiences are perceived as lacking institutional support, physicians may become more likely to disengage emotionally from their work. Therefore, transparent and supportive management of complaint processes may be crucial in maintaining physicians' professional confidence and motivation.

Institutional differences were also noteworthy. Physicians working in university hospitals and those holding academic positions reported lower quiet quitting tendencies compared with their counterparts in other settings. Qualitative research suggests that academic physicians derive professional satisfaction not only from clinical duties but also from scientific productivity, teaching roles, and career advancement opportunities[31]. This multidimensional professional fulfilment may strengthen occupational commitment and reduce withdrawal behaviours. However, in contexts where academic and clinical responsibilities coexist alongside substantial professional demands, as is often the case in Türkiye, organizational strategies aimed at supporting academic productivity and career development may be particularly important. Contrary to findings reported in some prior studies suggesting that quiet quitting is more prevalent among younger employees, no significant association between age and quiet quitting was observed in the present sample. This discrepancy may reflect the specific occupational context of physicians, whose professional identity, ethical obligations, and long training trajectories may moderate the relationship between age and disengagement in ways that differ from general workforce samples.

Consistent with the Job Demands–Resources model, our findings demonstrated that positive dimensions of work–life balance were positively associated with psychological well-being and negatively associated with quiet quitting, whereas negative spillover dimensions showed the opposite pattern[15].Hierarchical regression analyses further revealed that sociodemographic variables explained only a modest proportion of the variance in quiet quitting, whereas psychological and work–life balance factors substantially increased the explanatory power of the model. This stepwise increase highlights that quiet quitting behaviours are more strongly influenced by modifiable psychosocial and organizational factors than by relatively stable demographic characteristics.

Notably, positive work-to-life spillover emerged as the strongest predictor of quiet quitting. This finding underscores that enhancing the meaningful and enriching aspects of professional roles may be as important as addressing occupational demands and work-related stressors. Meta-analytic evidence suggests that organizational support, job satisfaction, and well-being reduce disengagement behaviours, whereas perceived injustice, conflict, and burnout increase them[29]. When employees feel that their efforts are neither recognized nor fairly rewarded, they may limit their engagement to formal role requirements[9,32]. Conversely, when work contributes positively to personal growth and life satisfaction, the need for psychological withdrawal may diminish.

Importantly, psychological well-being remained an independent protective factor even after controlling for work-related variables, highlighting the significance of individual resilience and the capacity to derive meaning from professional experiences. This finding suggests that physicians with higher levels of psychological well-being may be better equipped to cope with occupational stressors and maintain occupational functioning[25]. Consequently, strengthening psychological resources and supporting adaptive coping mechanisms may help reduce the tendency toward passive withdrawal behaviors such as quiet quitting.

At the same time, structural and organizational determinants of clinician well-being should not be overlooked. Multinational studies have demonstrated that poor work–life balance, insufficient staffing, and adverse working conditions are associated with burnout, turnover intentions, and compromised patient safety[24]. Healthcare professionals often prioritize systemic improvements—such as reduced administrative burden and increased patient interaction time—over individual resilience-focused interventions. Our findings similarly indicate that both individual and organizational approaches are required to effectively address disengagement behaviours. These results can be interpreted within the framework of the Job Demands–Resources (JD-R) model and in line with the hypotheses developed based on this theoretical framework.

Limitations

Several limitations should be acknowledged. First, the cross-sectional design precludes causal inferences regarding the relationships observed. Second, the reliance on self-reported data may have introduced risks of social desirability bias and common method variance. Third, the use of a snowball sampling strategy and online data collection may have limited the representativeness of the sample. In addition, the relatively low Durbin–Watson statistic observed in the regression analyses suggests a potential risk of residual autocorrelation; therefore, the strength of the identified associations should be interpreted with caution. Future research employing longitudinal designs, mixed-methods approaches, and intervention studies targeting work–life enrichment may provide a more comprehensive understanding of quiet quitting dynamics in the medical profession.

Conclusions

In conclusion, the present study demonstrates that quiet quitting among physicians is a multidimensional phenomenon shaped by psychological well-being, work–life balance, and organizational context rather than merely by individual motivational deficits. Strengthening the positive contributions of work to personal life and

promoting psychological well-being may play a key role in sustaining occupational functioning. Accordingly, healthcare systems should adopt holistic strategies that support both structural working conditions and individual psychological resources to maintain workforce sustainability and patient care quality.

Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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Author contributions

EMA: Conceptualization, Formal analysis, Methodology, Project administration, Writing - Original Draft, Writing - Review & Editing, Visualization, Software, Data curation, Investigation; ACK: Formal analysis, Methodology, Writing - Review & Editing, Visualization, Validation, Software, Data curation, Investigation; RAD: Formal

analysis, Writing - Review & Editing, Validation, Software, Data curation, Investigation; YDA: Writing - Review & Editing, Validation, Software, Data curation, Investigation.All authors have read and approved the final version submitted and take public responsibility for all aspects of the work.

Declarations

Competing interests
The authors declare no competing interests.

Ethics statement
The study was reviewed and approved by the Ethics Committee of Health Sciences University Bursa Yuksek Ihtisas Training and Research Hospital, under protocol number 2024-TBEK-2025/11–12.

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