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## Chapter

# Correlates of Mobbing among Medical Residents in a University General Hospital: The Experience from Greece and Review of Literature

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## Abstract

The term “mobbing” (moral harassment) in the workplace is defined as the systematic and persistent intimidation, the insult, the exclusion, and the unfair behavior toward a target person. There is little experience regarding mobbing in Greek hospitals, especially among medical residents. In this study, 92 medical residents from the University General Hospital of Patras, Greece (UGHP) were challenged to complete the Einarsen Negative Acts Questionnaire revised (NAQ-R) along with their demographic characteristics. Sector specialty of participants: Internal Medicine, Surgical, and Laboratory Sector. No statistically significant difference occurred relative to sex ( $p = 0.14$ ), training ( $p = 0.735$ ), the specialty years ( $p = 0.478$ ), or years of work as a trainee in UGHP ( $p = 0.052$ ). Statistically significant difference ( $p = 0.0174$ ) occurred with respect to: (a) age, where at age group 25–35 with regard to age groups 35–35 and 45–55, and (b) Sector ( $p = 0.0043$ ) with higher score in the Sector of Surgery, and lowest in the Laboratory Sector (mean = 45.4). Not much data are available regarding the mobbing phenomenon among medical residents worldwide. A review of the literature is also attempted in this study. This research is a pioneer in the Greek medical sector.

**Keywords:** mobbing, medical residents, university hospital, Negative Acts Questionnaire, moral harassment, workplace

## 1. Introduction

Smooth interpersonal relationships in the workplace environment are critical to the unobstructed function of an organization [1]. The term “mobbing” (moral harassment) in the workplace is defined as the systematic and persistent intimidation, the insult, the exclusion, and the unfair behavior toward a target person [2–4].

According to Pranjić et al. [5], the phenomenon of moral harassment in doctors has five dimensions. First, an attempt is made to underestimate their work with humiliation in front of colleagues or patients, bad criticism, and discipline implied by threats. The second dimension includes sarcasm and use of any form of violence to undermine the victim's personal integrity. The third dimension involves the isolation of the victim by concealing useful information and unjustified non-authorization or promotion. There is undue pressure through increased workload and deadlines that cannot be achieved. The fifth dimension aims to destabilize the victim through leakage of malicious rumors, continuous depreciation, and sudden removal of jurisdictions [5].

The causes of the phenomenon include competition, envy, diversity (gender, religion, sexuality, and social origin), and a workplace environment with a great deal of workload and simultaneous conflict of roles [6]. The phenomenon is associated with psychological stress and low job satisfaction and the consequences are detrimental to young doctors as revealed by many studies [2, 5, 7].

In Greece, despite that 13.2% of workers declare that they have been victims of mobbing, there is no relevant legislation. Only laws related to the assault of human dignity exist [8, 9]. The lack of clear legal framework makes it thus very difficult for the victim to take legal action against the offenders as he/she "bears the burden of proof" [2, 6, 10]. The recognition of the problem is often difficult, as the person is devastated psychologically and has no courage to defend himself/herself or is afraid of retaliation [1, 11–13].

The difficult situation of the victim is compounded by the current economic crisis in Greece. Under the hardship of finding a job, the need for survival becomes a priority increasing the tolerance of violence [14]. As a result, the phenomenon of mobbing is being added as a problem of the hospitals in the public sector together with the financial constraints, the pay cuts, and the brain drain [15, 16]. At the same time, there is increasing pressure to augment the efficiency of organizations, which creates a fertile ground for mobbing against young doctors [5, 13, 17–23].

In Greece, although there is increasing evidence that the phenomenon is present among young doctors, no such study is ever conducted in the medical residents of a University Hospital [18, 20]. Greek University Hospitals accept a plethora of patients with severe diseases. The University General Hospital of Patras accepts over 100,000 persons per year in the Emergency Sector, and over 40,000 hospitalized patients [24]. Because of the economic crisis, the brain drain of young doctors in Greece leads to fewer and fewer medical residents getting the job done in a difficult working environment with demanding working hours and reduced wages [15]. As a result, the outcomes of the present study are significant in order to delineate the working conditions of the remaining young doctors.

The University General Hospital of Patras was therefore selected for this study, as it receives a large number of patients from all over the Western Greece region; the amount of workload is consequently large. In addition, the number of medical residents was such in order to obtain a satisfactory sample size; this survey is a pioneer in the health sector in Greece.

The basic research hypothesis of the present study was that the phenomenon of mobbing among medical residents might be present at a considerable intensity in Greece. The following scientific questions are raised and addressed in this study: Is there a mobbing effect in medical residents? Are there independent associations between mobbing, genders, age, educational level sector the residents work in? On the basis of this hypothesis, the ultimate goal of this investigation was to demonstrate to what extent there is mobbing among medical residents.

## 2. Material and method

### 2.1 Study sample

Medical residents were asked to state their gender, age group, the sector where they work (Laboratory, Internal Medicine, and Surgery), and how many years they were specialized in total, but also in the present organization. The UGHP was chosen as it accepts a plethora of incidents from across the region of Western Greece and therefore the amount of workload is large. Written approval was obtained from the UGHP Ethics Committee (decision number 40/18.01.18). Moreover, a written statement was submitted by the researchers to the UGHP Ethics Committee safeguarding the anonymity of the participants; to ensure anonymity, each respondent was given an identical envelope in which he/she enclosed his/her answers. During the completion of the questionnaires, any questions of understanding were answered and the necessary clarifications were given.

The research population was 243 medical residents who, according to the records of the UGHP Human Resources Sector, were working on the organization at the time of the study; despite efforts to maximize participation, the sample of participants for the present study consisted of a total of 92 individuals (participation rate: 37.9%), from all specialties in the Laboratory, Internal Medicine and Surgery Sector. The remaining medical residents refused to participate with the most common justifications, the lack of time due to excessive workload (78%), or indifference (19%), being cautious about the reassurances of anonymity (3%). There were even aggressive behaviors towards the researcher of the present study.

### 2.2 Questionnaires

A questionnaire covering socio-demographic (gender, age, education), and work-related parameters (sector-specialty; total years of work as a medical resident; years of work as a medical resident especially at UGHP) was distributed to study participants. The Einarsen Negative Acts Questionnaire revised (NAQ-R) was used as the tool to measure exposure to mobbing in the workplace environment. This questionnaire has a high coefficient of internal coherence (Cronbach-alpha = 0.915). Kakoulakis et al. have validated it in Greek [4, 7]. The author of the present study requested and got written approval for the use of the questionnaire.

NAQ includes a total of 23 questions. Of these, questions 1, 3, 4, 11, 12, 13, 14, 16, 18, 19, and 21 pertain to a specific scale of labor-related intimidation. Questions 2, 5, 6–10, 15, 17, 20, and 22 relate to a scale of labor-related intimidation regarding the worker's personality. Question 23 concerns how often the respondent considers that there is moral harassment in his/her work after being given the definition. The questions are rated from 1 to 5 (5 point Likert scale), with the scale corresponding to: 1 = never, 2 = rarely, 3 = once per month, 4 = once a week, 5 = every day. The above answers are added together and the total score results in values ranging from 23 (lower) to 115 (higher), and the higher the sum, the higher the mobbing phenomenon. Based on the weighting of the Greek population, the interpretation of the results is as follows: nonexistence of mobbing: 23–25 points; low levels of mobbing: 26–34 points; moderate levels: 35–44 points; high levels: 45–55 points; very high levels of mobbing—frequent and extreme aggressive behaviors: 56 points or more [7].

## 2.3 Statistical analysis

Descriptive statistics were calculated for the study variables; continuous variables were summarized as mean (standard deviation, SD) and categorical ones as frequencies and percentages. Similarly, descriptive statistics were estimated for NAQ-22 items and overall score.

At the univariate analysis, the associations between NAQ-22 overall score with sociodemographic and work-related factors were evaluated with t-test and analysis of variance (ANOVA), as appropriate; the assumption of normality was verified with Shapiro-Wilk test.

At the multivariate approach, the independent associations between NAQ-22 score (treated as the dependent variable), sociodemographic and work-related factors (treated as independent variables) were evaluated by multivariate linear regression analysis. Model fit was evaluated with the examination of jackknifed residuals. The level of statistical significance was set at 0.05. Statistical analysis was performed with SPSS® version 16 statistical software (SPSS Inc, Chicago, IL, USA).

## 3. Results

### 3.1 Descriptive statistics

The sample of the present study consisted of 92 individuals, all medical residents in the UGHP. The demographic features of participants are shown in **Table 1**. Fifty-two percent (n = 48) were females. In terms of age, the majority (77.2%, n = 71) was 25–35 years old. With regard to sector-specialty, 41.3% (n = 38) of participants worked at the Internal Medicine, 31.5% (n = 29) Surgical, 21.7% (n = 20) Laboratory, 3.3% (n = 3) Psychiatric, and 2.2% (n = 2) at Clinical-laboratory Sector, respectively. Only 9.9% (n = 9) had an MSc and 7.7% (n = 7) a PhD degree. The majority of participants (59.8%, n = 55) worked overall as medical residents for 2–5 years and especially at UGHP for 0–2 years (51.1%, n = 47).

The questions that were related to possible negative issues at the workplace of participants have represented: Participants asserted that they had been “frequently” ordered to do work below their level of competence (M = 3.68), as well as having key areas of responsibility removed or replaced with more trivial or unpleasant tasks (M = 3.63). Also, participants’ answers, regarding the statement “Being exposed to an unmanageable workload”, were placed between the scale “sometimes” and “frequently” (M = 3.34). Furthermore, participants claimed that “sometimes” had been shouted at or being the target of spontaneous anger (M = 2.88) and under pressure not to claim something to which by right they were entitled (M = 2.83). Accordingly, “sometimes” someone withholds information which affects their performance (M = 2.79). Also, “sometimes” having been their opinions ignored (M = 2.75), were under persistent criticism of their errors or mistakes (M = 2.74), as well as “sometimes” there were spreading of gossip and rumors about them (M = 2.73) (**Table 2**).

Additionally, participants’ answers were placed between the scale “rarely” and “sometimes” as for the statements “Repeated reminders of your errors or mistakes” (M = 2.62), “Being given tasks with an unreasonable deadline” (M = 2.55), and “Excessive monitoring of your work” (M = 2.38). Moreover, participants declared that “rarely” having been humiliated or ridiculed in connection with their work (M = 2.25),

Variables	Categories	n (%)
Gender	Male	44 (47.8)
	Female	48 (52.2)
Age	25–35	71 (77.2)
	35–45	19 (20.7)
	45–55	2 (2.2)
Sector-Specialty	Laboratory	20 (21.7)
	Clinical-laboratory	2 (2.2)
	Internal Medicine	38 (41.3)
	Surgery	29 (31.5)
	Psychiatric	3 (3.3)
Level of education	PhD	7 (7.7)
	MSc	9 (9.9)
	Medical degree	75 (82.4)
Total years of work as a medical resident	0–2	27 (29.3)
	2–5	55 (59.8)
	6–10	10 (10.9)
Years of work as a medical resident especially at UGHP	0–2	47 (51.1)
	2–5	40 (43.5)
	6–10	5 (5.4)

*N: Frequency; f%: Valid Percent.*

**Table 1.**  
*Sociodemographic and work-related parameters in the study sample (n = 92).*

ignored or facing a hostile reaction when they approach (M = 2.22), having allegations made against them (M = 2.16), having been ignored or excluded (M = 2.13), having insulting or offensive remarks made about their attitudes or private life (M = 2.10), having been a victim of mobbing in their work (M = 2.02) or the subject of excessive teasing and sarcasm (M = 2.00). Moreover, participants argued that there were “rarely” intimidating behaviors, (such as finger-pointing, invasion of personal space, shoving, blocking their way) (M = 1.78), hints or signals from others that made them quit their job (M = 1.68) or practical jokes, carried out by people they don’t get along with (M = 1.68). In conclusion, participants’ answers were placed between the scale “never” and “rarely”, with regard to the statement “Threats of violence or physical abuse or actual abuse” (M = 1.36).

### **3.2 Associations between mobbing and potential correlates: results from univariate analysis**

In this section, the main research aim will be examined which is to find possible dependencies between negative issues at work with demographic characteristics. Internal reliability was very satisfying as Cronbach Alpha value is  $0.932 > 0.7$ .

Questions	Mean	Std. deviation
<b>Labour-related intimidation</b>		
Being ordered to do work below your level of competence	3.68	1.30
Being exposed to an unmanageable work load	3.34	1.30
Being shouted at or being the target of spontaneous anger	2.88	1.20
Being given tasks with unreasonable deadline	2.55	1.30
Excessive monitoring of your work	2.38	1.10
Being humiliated or ridiculed in connection with your work	2.25	1.20
Being ignored or facing a hostile reaction when you approach	2.22	1.20
Being ignored or excluded	2.13	1.10
Have you been victim of mobbing in your work?	2.02	1.10
Being the subject of excessive teasing and sarcasm	2	1.10
Hints or signals from others that you should quit your job	1.68	1.04
<b>Labour related intimidation regarding the workers' personality</b>		
Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	3.63	1.2
Pressure not to claim something to which by right you are entitled (e.g. sick leave, holiday entitlement, travel expenses)	2.83	1.3
Someone withholding information which affects your performance	2.79	1.2
Having your opinions ignored	2.75	1.1
Persistent criticism of your errors or mistakes	2.74	1.1
Spreading of gossip and rumors about you	2.73	1.3
Repeated reminders of your errors or mistakes	2.62	1.1
Having allegations made against you	2.16	1.0
Having insulting or offensive remarks made about your person, attitudes or your private life	2.1	1.2
Intimidating behaviors such as finger-pointing, invasion of personal space, shoving, blocking your way	1.78	1.1
Practical jokes carried out by people you don't get along with	1.68	1.0
Threats of violence or physical abuse or actual abuse	1.36	0.9

**Table 2.**  
*Descriptive statistics for NAQ items.*

Due to high internal reliability, questions that referred to negative issues at work have been grouped in a new variable named "Score of negative issues at work" using the unbiased estimator of mean value. The mean value of "Score of negative issues at work" is 2.45 indicating that negative issues happen rarely to sometimes while standard deviation is 0.743.

**Table 3** indicates results of the univariate analysis regarding the associations between NAQ overall score, sociodemographic, and work-related features. **Table 3** indicates that mean value of variable "Score of negative issues at work" differs in different categories of demographic features "Age" ( $p\text{-value} = 0.0174 < 0.05$ ,

Variable	Mean (SD)	p-value
Gender		
Males	53.6136 (17.8498)	0.1473 <sup>t</sup>
Females	58.7917 (16.1324)	
Age		
25–35	58.4930 (16.3059)	<b>0.0174<sup>A</sup></b>
35–45	51.0000 (17.5816)	
45–55	29.5000 (7.7782)	
Sector-specialty		
Laboratory	45.3500 (13.0274)	<b>0.0043<sup>A</sup></b>
Clinical-laboratory	40.5000 (4.9497)	
Internal Medicine	57.6842 (17.0343)	
Surgery	62.5517 (17.1435)	
Psychiatric	62.3333 (7.7675)	
Years of work as a medical resident		
0–2	58.8889 (18.4835)	0.4776 <sup>A</sup>
2–5	55.9636 (15.3067)	
6–10	51.3000 (22.5490)	
Years of work as a medical resident at UGHP		
0–2	59.3830 (18.2525)	<b>0.0449<sup>A</sup></b>
2–5	54.6750 (15.3529)	
6–10	40.60000 (7.8294)	

t: p-value derived from t-test; A: p-values derived from analysis of variance.

**Table 3.**

Univariate associations of NAQ overall score with demographic features. Bold cells denote statistically significant associations.

ANOVA), “Sector-Specialty” (p-value = 0.0043 < 0.05, ANOVA) and “Years of work as a medical resident at UGHP” (p-value = 0.4776 < 0.05, ANOVA).

### 3.3 Associations between mobbing and potential correlates: results from multivariate regression analysis

Results of multiple regression model fit with dependent variable “Score of negative issues at work” and independent variables the demographic features. Null hypothesis that model does not fit and its data is rejected (p-value = 0.002 < 0.05). Level of adjustment is moderate as  $R^2 = 0.212 < 0.4$ .

**Table 4** indicates coefficients of multiple regression model fit with dependent variable “Score of negative issues at work” and independent variables the demographic features. Null hypothesis is that coefficients are zero and the alternative is that they are statistically significant. Statistical significant are considered the coefficients of variables “Age” (p-value = 0.035 < 0.05), “Sector-Specialty” (p-value = 0.001 < 0.05). Linear model is described by the following mathematical formula:



Independent variables	B	BETA	p-value
Gender	0.1	0.06	0.539
Age	-0.4	-0.2	<b>0.035</b>
Sector-specialty	0.2	0.3	<b>0.001</b>
Level of education	-0.04	-0.03	0.722
Years of work as a medical resident	0.1	0.1	0.404
Years of work as a medical resident at UGHP	-0.08	-0.07	0.620

*Dependent Variable: Score of negative issues at work.*

**Table 4.**

Results of the multivariate regression analysis examining the associations between NAQ (dependent variable), sociodemographic and work-related parameters.

$$\text{“Score of negative issues at work”} = 0.001 - 0.365 \times \text{Age} + 0.222 \times \text{Sector} - \text{Specialty}. \quad (1)$$

Results of independent variables affection in dependent variable “Score of negative issues at work” using BETA coefficients were as follows: Variable “Age” affects negatively (BETA = -0.238) dependent variable of model, while “Sector-Specialty” positively (BETA = 0.349). BETA coefficients have values in the interval [-1.1]. Values close to 1 indicate maximum positive affection while values close to -1 maximum negative. Values close to 0 indicate no affection.

The sample of medical residents in this study shows an average score of  $56.32 \pm 17.080$  for NAQ-22, which means on average that there were very high levels of mobbing- frequent and extreme aggressive behaviors in the medical residents of UGHP. No statistically significant difference occurred in NAQ-22 relative to sex ( $p = 0.14$ ), training ( $p = 0.735$ ), the specialty years ( $p = 0.478$ ), or years of work as a trainee in UGHP ( $p = 0.052$ ). On the other hand, statistically significant difference ( $p = 0.0174$ ) occurs with respect to: (a) age, where at the age group 25–35 the highest value is observed (mean = 58.5) in relation to ages groups 35–35 (mean = 51.0) and 45–55 (mean = 29.50), and (b) Sector, ( $p = 0.0043$ ) with higher score in the Division of Surgery (mean = 62.55), and lowest in the Laboratory sector (mean = 45.4).

### 3.4 Multivariate regression analysis for subscales of NAQ

**Table 5** indicates the results of Cronbach Alpha coefficient for subscales of NAQ. Reliability of “labor related intimidation” was  $\alpha = 0.864$  while “labor related intimidation regarding the worker’s personality” 0.902. Reliability of the total scale was 0.932.

Using as dependent variable “Labor related intimidation”, statistically significant are considered the coefficients of variables “Age” ( $p\text{-value} = 0.003 < 0.05$ ), “Sector-Specialty” ( $p\text{-value} = 0.001 < 0.05$ ) and the coefficient of constant ( $p\text{-value} < 0.001$ ). Linear model is described by the following mathematical formula:

$$\begin{aligned} \text{Labor related intimidation} = & 2.987 + 0.087 \times \text{Gender} - 0.544 \times \text{Age} + 0.237 \\ & \times \text{Sector} - \text{Specialty} - 0.118 \times \text{Level of education(A)} \\ & + 0.112 \times \text{Years of work as a medical resident(A)} - 0.098 \\ & \times \text{Years of work as a medical resident at UGHP(A)}. \quad (2) \end{aligned}$$

Category	Questions	Cronbach Alpha
Labour related intimidation	1, 3, 4, 11, 12, 13, 14, 16, 18, 19, 21	0.864
Labour related intimidation regarding the worker's personality	2, 5, 6, 7, 8, 9, 10, 15, 17, 20, 22	0.902
Victim of mobbing in work	23	—
Score of negative issues at work	1–23	0.932

**Table 5.**  
 Reliability analysis for subscales of NAQ.

Using as dependent variable “Labor related intimidation regarding the worker's personality”, statistically significant is considered the coefficient of variable “Sector-Specialty” (p-value = 0.006 < 0.05). No appropriate model was formulated.

Using as dependent variable “Victim of mobbing in work”, statistically significant is considered only the constant (p-value = 0.034 < 0.05). No appropriate model was formulated.

Using as dependent variable “Score of negative issues at work” statistically significant are considered the coefficients of variables “Age” (p-value = 0.035 < 0.05), “Sector-Specialty” (p-value = 0.001 < 0.05) and the coefficient of constant (p-value = 0.0001 < 0.05). Linear model is described by the following mathematical formula:

$$\begin{aligned} \text{Score of negative issues at work} = & 2.122 + 0.092 \times \text{Gender} - 0.365 \\ & \times \text{Age} + 0.222 \times \text{Sector} - \text{Specialty} - 0.044 \times \text{Level of education(D)} \\ & + 0.132 \times \text{Years of work as a medical resident(D)} - 0.084 \\ & \times \text{Years of work as a medical resident at UGHP(D)}. \end{aligned} \quad (3)$$

## 4. Discussion

In our study, statistically significant differences occurred with respect to age and Sector. Regarding the age, medical residents of 25–35 years were subject to highest values of mobbing (mean = 58.5) in relation to ages groups 35–35 (mean = 51.0) and 45–55 (mean = 29.50). Regarding the Sector, the higher score was objected in the Surgery Sector (p = 0.0043), (mean = 62.55), and lowest in the Laboratory Sector (mean = 45.4).

The sample of the present study consisted of 92 individuals, all medical residents in the UGHP. Males and females were almost equal and regarding age most of the participants were 25–45 years old. As far as sector specialty was concerned, the majority of individuals worked at the Internal Medicine Sector, at the Surgical Sector, and at the Laboratory Sector. In respect of the level of education, most of the participants had a medical degree and worked as medical residents at UGHP for 0–5 years.

Generally, negative issues at work happened rarely to sometimes. Participants stated that they had been frequently ordered to do work below their level of competence as well as having key areas of responsibility removed or replaced with more trivial or unpleasant tasks. Negative incidents at work happened more frequently to young participants age 25–35 years old, individuals with specialty in Internal Medicine or Surgery, and those who worked 0–2 years as medical residents at UGHP.

Specifically, participants stated that labor-related intimidation happens sometimes while labor-related intimidation regarding the workers' personality or being a victim of mobbing in work rarely. Analyzing labor related intimidation, participants stated that they had been frequently ordered to do work below their level of competence as well as having key areas of responsibility removed or replaced with more trivial or unpleasant tasks.

In our study, very high levels of mobbing - very frequent and extreme aggressive behaviors emerged (score  $56.32 \pm 17.080$  for NAQ-22). Regarding the Greek hospitals, these findings are consistent with the study of Gavrielatos [18] that referred to a sample of medical residents using the same tool (NAQ scale) [18]. Data from a cross-sectional quantitative empirical study from University General Hospital from Heraklion, Crete, in Greece, revealed that among health care professionals 41.3% of the participants were subjects of serious mobbing and 31.3% of occasional mobbing, with doctors more vulnerable from nurses. Also the upper the more highly educated were victims of mobbing. This survey also used the Negative Acts Questionnaire-Revised [25]. In accordance with those results is a study conducted in Bosnia and Herzegovina; where over three-quarters of doctors declared they were exposed to moral harassment, and with surveys in Turkey and Portugal, where non-specialist doctors were exposed to moral harassment at a rate of 87.7% and 60% respectively [5, 21]. In a survey conducted among primary health care workers in Turkey, 31.1% of health workers declared having been victims of mobbing in the last one year with a frequency of 1–3 times per year [26]. Lower rates were observed in hospital doctors in the United Kingdom and Finland [5, 21]. With international evidence demonstrating that in the healthcare sector the phenomenon of moral harassment is reinforced, but on the other hand not properly evaluated by the victim due to the stress of survival amidst the economic crisis and daily exposure to illness and death, these percentages are particularly important [6, 21, 27, 28].

In another study from Turkey among healthcare professionals, half of the participants declared exposure to “mobbing behaviors for targeting reputation” and to “mobbing behaviors for targeting occupational status” [29]. A qualitative study from Greece among health professionals in a public hospital revealed that the mobbing phenomenon was tangible and the abuse was mainly verbal and behavioral [30].

As far as gender is concerned, findings in literature are controversial [6, 20, 26, 31, 32]. In the present study, there was no statistically significant difference in NAQ-22 related to gender. A statistically significant difference was observed only in questions referring to the individual's intimidation about his/her personality, such as question 2 (Being humiliated or ridiculed in connection with your work), question 5 (Spreading of gossip and rumors about you), question 7 (Having insulting or offensive remarks made about your person), and question 16 (Being given tasks with an unreasonable deadline). In the above-mentioned questions, women had a higher score than their male counterparts. Despite the fact that the present study does not present a statistically significant difference in the NAQ-22 between the two sexes, those responses of female medical residents should be taken under consideration and redefine the attitude towards female doctors. A survey conducted in Turkey also revealed high rates of mobbing in females doctors, participants with low income, and also workers from other provinces [33, 34]. On the other hand, a survey from Turkey in healthcare professionals from three different cities included workers from private hospitals, state hospitals, university hospitals, and other health centers revealed that the level of mobbing did not vary depending on gender, but on the marital status and age. Singles and younger employees were subjected to mobbing more than the married and older ones [35].

In the international literature, there is a controversy about the relationship between age and the occurrence of the phenomenon of mobbing [20, 36]. In Uruguay 40.4% of hospital employees reported being the victim of mobbing at least once a week, with the majority being older and more highly educated [37]. In the current study, there appeared to be a particularly higher NAQ score in the youngest doctors (25–35-year-old). This pattern is in line with the study by Gavrielatos for physicians [18]. Possible explanations may include that older medical residents have learned how to handle similar incidents from their job experience or they are perpetrators themselves [38].

Regarding previous education, there was no statistically significant difference between medical residents with a medical degree, MSc degree, or PhD in our survey. A statistically significant difference occurred only in question 15 “Practical jokes carried out by people you don’t get along with”, with the maximum occurring in the case of people with an MSc degree. This finding is in part consistent with Gavrielatos’s study, where doctors with an MSc or PhD seemed to be subject to higher mobbing rates [18]. Other studies also demonstrated that the selected victims were often more qualified than others [2, 39]. In Turkey healthcare professionals with a doctoral education level were exposed more to mobbing than their colleagues with lower education [40, 41].

In accordance, there is also a study conducted in Uruguay among hospital employees. In this study, there was more prevalent mobbing among the employees who had higher education [37].

According to the results of the present study, the highest rates of mobbing were observed in the Surgical Sector (62.55), whereas in the Laboratory sector the lowest (45.35). Issues of increased workload in connection with a lack of division of duties and responsibilities in connection with management deficiencies of the Surgical Sector are a possible explanation of these results. A strict hierarchical structure in an organization, combined with the ambiguity of tasks and lack of distinct responsibilities, may intensify and fuel the phenomenon as tensions are favored. Another potentially important parameter is the non-recognition of the efforts made by the employees, resulting in frustration and loss of confidence [2, 6, 19, 38, 42–44].

There was no statistically significant difference with respect to years of being a medical resident in this study. A difference was noted only in question 2 “Being humiliated or ridiculed in connection with your work” where people with 2–5 years of service (mean = 2.49) appeared to be more harassed than people with years of service 0–2 (mean= 2.11) and 6–10 (mean = 1.30). This is in contradiction with the findings of Gavrielatos [18] and Katsilaki [20], where those who accept very low levels of mobbing have more years of experience [18, 20, 45]. A cross-sectional study in a Malaysian Public University Hospital, using the validated Malay version of the 23-item Negative Acts Questionnaire—revised, revealed that workers in less than ten years were the victims [46].

## **5. Conclusion: limitations**

Given the devastating effects of mobbing on the individual and the organization, management should take preventive and countermeasure acts [5]. Keeping the medical residents and Heads of the Sectors informed about the mobbing phenomenon is a positive step to that direction along with recording the current situation. The phenomenon of moral harassment requires immediate confrontation as the very high

levels of mobbing observed should sound the alarm. In health care working environment hierarchies, respect is often related to power and status [47]. On the other hand, respect should be related to “positive attitudes toward human worth” especially when vulnerable individuals are involved. As far as medical residents are concerned, their time, opinions and privacy should not be ignored [47]. Trust and job satisfaction should build respect and professionalism [47].

Regarding limitations, the low response rate of the doctors in the completion of the questionnaire, despite the assurances of the anonymity of the participants, has troubled the investigators of this survey. Despite necessary explanations to the participants and the preservation of anonymity, the low response rate may have signaled selection bias.

The interpretation of the results of relevant surveys should be based on the particular characteristics of the organization in which the study is conducted and the nature of the work being done [3]. Comparing data with other research papers on the same subject is difficult when there are not used the same measuring tools [7]. Finally, the present research has a cross-sectional character, which on the one hand facilitates sample selection from the general population, but on the other hand, it cannot give information about the sequence of time or search for the cause of facts.

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## **Conflict of interest**

The author declares no conflict of interest


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