Anonym Anonymous

Anoym

new

Articles

Uşak Üniversitesi

Document Details

Submission ID

trn:oid:::1:3140477628

Submission Date

Jan 29, 2025, 1:37 PM GMT+3

Download Date

Jan 29, 2025, 1:43 PM GMT+3

File Name

Exploitation_and_Psychological_Strain_in_Residency_Training.docx

File Size

67.6 KB

10 Pages

7,945 Words

46,791 Characters

*% detected as AI

AI detection includes the possibility of false positives. Although some text in this submission is likely AI generated, scores below the 20% threshold are not surfaced because they have a higher likelihood of false positives.

Caution: Review required.

It is essential to understand the limitations of AI detection before making decisions about a student's work. We encourage you to learn more about Turnitin's AI detection capabilities before using the tool.

Frequently Asked Questions

How should I interpret Turnitin's AI writing percentage and false positives?

The percentage shown in the AI writing report is the amount of qualifying text within the submission that Turnitin's AI writing detection model determines was either likely AI-generated text from a large-language model or likely AI-generated text that was likely revised using an AI-paraphrase tool or word spinner.

False positives (incorrectly flagging human-written text as AI-generated) are a possibility in AI models.

AI detection scores under 20%, which we do not surface in new reports, have a higher likelihood of false positives. To reduce the likelihood of misinterpretation, no score or highlights are attributed and are indicated with an asterisk in the report (*%).

The AI writing percentage should not be the sole basis to determine whether misconduct has occurred. The reviewer/instructor should use the percentage as a means to start a formative conversation with their student and/or use it to examine the submitted assignment in accordance with their school's policies.

What does 'qualifying text' mean?

Our model only processes qualifying text in the form of long-form writing. Long-form writing means individual sentences contained in paragraphs that make up a longer piece of written work, such as an essay, a dissertation, or an article, etc. Qualifying text that has been determined to be likely AI-generated will be highlighted in cyan in the submission, and likely AI-generated and then likely AI-paraphrased will be highlighted purple.

Non-qualifying text, such as bullet points, annotated bibliographies, etc., will not be processed and can create disparity between the submission highlights and the percentage shown.

Exploitation and Psychological Strain in Residency Training: Workload and Shift Violations in Turkish Medical Schools and Research Hospitals

Abstract

Background: The path to specialisation in Turkey is a highly demanding and costly process. After completing six years of intensive medical education, general practitioners must pass the highly competitive Medical Specialisation Examination (TUS) to enter residency training. The difficulty of this process has contributed to the growing shortage of specialist doctors in Turkey. Particularly, the heavy working conditions and workplace bullying by senior faculty members further exacerbate the challenges faced by residents. Despite the introduction of the 2022 Medical Specialisation Training Regulation (TUEY) aimed at improving working conditions, excessive workload, non-compliance with shift regulations, and psychological pressures persist.

Methodology: This study employs a phenomenological research approach to explore the experiences of 25 medical residents in Turkey. Participants were purposefully selected from 25 different medical faculties across the country, representing various specialisations and hospital settings. Data were collected through semi-structured interviews focusing on shift regulations, psychological impacts, and compliance with TUEY. The collected data were systematically analysed using MAXQDA software, and thematic content analysis was applied.

Findings: The study identified four main themes: (1) Shift Scheduling and TUEY Implementation – Most participants reported that the rule of a maximum of eight shifts per month was generally observed, but post-shift rest periods were often denied. (2) Psychological and Emotional Well-being of Residents – Excessive workload and stress were found to negatively affect residents' mental health and personal lives. (3) Supervisors' Role and Pressure Mechanisms – The findings suggest a lack of sufficient oversight mechanisms for TUEY compliance, with supervisors continuing to delegate excessive workloads to residents. (4) Psychological Pressure from Faculty Members – Residents reported experiencing verbal abuse, belittlement, and being assigned menial tasks by faculty members, leading to professional dissatisfaction and increased early resignation rates.

Conclusion: Despite the existence of TUEY, medical faculties in Turkey fail to fully adhere to the regulations. Medical residents face severe issues, including excessive workload, lack of post-shift rest, psychological pressure, and inadequate training. To address these problems, independent oversight mechanisms should be established, ethical training should be provided to faculty members, and legal support should be made available to residents.

Keywords: Medical residency training, Workload in healthcare, Physician burnout, TUEY, Specialist doctor shortage in Turkey

Background

Medical education in Turkey, as in the rest of the world, is a highly challenging and costly process [1]. In Turkey, this journey begins with students securing a place in medical school by ranking within the top 1% in a nationwide university entrance examination taken by approximately three million candidates [2]. Those who achieve this success undergo six years of rigorous training before graduating as general practitioners [3]. General practitioners, who have not yet completed specialisation training, typically work in hospital emergency departments, primary healthcare institutions, or family medicine units after graduation [4]. Those who do not wish to work in these areas must sit the Medical Specialisation Examination (TUS), a highly competitive and demanding test covering all fields of medicine, to pursue specialisation [5].

Specialist training generally lasts three years in basic medical sciences (e.g. anatomy, physiology, public health), four years in internal medicine disciplines (e.g. paediatrics, internal medicine), and five years in surgical fields (e.g. general surgery, obstetrics and gynaecology). However, depending on the complexity of the field and specific circumstances, these durations may be extended [7]. Due to the challenging working conditions and low salaries in the private sector, high-achieving medical graduates in Turkey tend to prefer employment in public hospitals. The relatively high probability of securing a public sector position and the comparatively better salaries in state institutions reinforce this preference [6, 8].

The number of specialist doctors per 1,000 people in Turkey is less than half the average in European Union (EU) countries. While Turkey has 2.2 doctors per 1,000 people, the OECD average is 3.7 [9]. As a result, residency training is significant. The high demand for specialist doctors further

underscores the critical role of residency education. However, due to medical malpractice lawsuits and the challenges of residency training, many internal medicine and surgical disciplines struggle to attract sufficient applicants, leaving numerous training positions unfilled [10]. This exacerbates the shortage of specialist doctors in Turkey, making the issue increasingly complex.

In this context, ophthalmology, otorhinolaryngology, child and adolescent psychiatry, and plastic surgery are among the most preferred disciplines for residency training, whereas general surgery and neurosurgery struggle to fill their quotas [11]. Additionally, the demanding nature of residency training forces many residents to discontinue their education prematurely [12].

During the process of specialist medical training, certain disciplines frequently experience exploitation, psychological pressures, and shift violations. Due to unhealthy working conditions, many residents are forced to abandon their training [13,14,15,16,17,18]. With increasing attention from medical associations and public discourse on the challenges faced by residents [19], these issues have gained political and governmental attention, particularly in the post-pandemic period [20,21,22,23].

One of the most striking examples of these problems was the tragic death of Dr Rümeysa Berin Şen, a resident in the Obstetrics and Gynaecology Department at a City Hospital. She lost her life in a car accident after completing a 36-hour shift [24]. Following this incident, her colleagues voiced their concerns in the media, stating: *"Exhausted doctors are dying; 36-hour shifts must end"* once again bringing the dire working conditions of medical residents into the spotlight [25].

Commonly raised concerns include the requirement for residents to work up to 15 shifts per month, endure 36-hour-long shifts, and suffer psychological pressure from academic supervisors. Many professors delegate their own duties to residents under the guise of "learning," further exacerbating the workload [26]. Additionally, administrative tasks, such as paperwork and bureaucratic documentation, which should be handled by clerks, are often assigned to residents, adding to their burden [27].

Although numerous reports have highlighted these problems in the past, criticisms persist regarding the Ministry of Health's failure to take concrete action. The inhumane working conditions of medical residents have even been featured in television programmes, yet many residents have been forced to conceal their identities for fear of retaliation or expulsion from training. This further underscores the systemic shortcomings in the residency training process and the inadequacy of existing solutions.

The challenges of the pandemic period led to a wave of resignations among residents. Following Dr Rümeysa Berin Şen's tragic death, efforts to address the deficiencies in residency training gained momentum. In response, the Minister of Health, Dr Fahrettin Koca, first held meetings with medical students and later consulted with representatives of residents from various universities. On 16 December 2021, a two-and-a-half-hour meeting was held, during which key issues such as working conditions, shift durations, workplace violence, and malpractice risks were discussed, and potential solutions were evaluated.

Subsequently, the Regulation on Medical and Dental Specialisation Training, published in the Official Gazette on 3 September 2022 (Issue No. 31942), introduced a set of reforms aimed at restructuring residency training.

The most notable amendments in the regulation are summarised in five key articles [28]:

- A specialty student is an individual who receives specialty training in programs and carries out research and practice.
- A specialty student cannot be assigned to tasks unrelated to education. However, in extraordinary circumstances such as earthquakes or epidemics, they may be assigned for a total period not exceeding six months, and those who are unable to complete their training due to such assignments may be granted an additional period of up to six months.
- Duty shifts (on-call) must be arranged so that they do not occur more frequently than once every three days and do not exceed eight shifts per month. A student who works a night duty shift does not provide healthcare services the following day.
- Training must be provided in accordance with the curriculum and standards, and the institution must supply the infrastructure that meets educational and social needs.
- The specialty student works under the supervision of instructors and is obligated to adhere to ethical principles.

Although this Regulation (TUEY) includes many positive provisions regarding the training of resident physicians, certain issues have arisen during its implementation. Strict adherence to all articles of the Regulation is of great importance for improving the training processes of resident physicians.

In Turkey, laws and regulations come into force and become obligatory for implementation from the date they are published in the Official Gazette. However, it has been observed that, in some hospitals where resident physicians receive their training, department chairs and instructors have engaged in practices that violate the "Regulation on Specialty Training in Medicine and Dentistry" (TUEY), published on September 3, 2022. In particular, the preference guide systems provided by certain TUS (Medical Specialty Examination) preparatory courses indicate that the provisions of TUEY are not being followed in some training hospitals [29, 30].

Although four months have passed since the Regulation came into effect, it has been determined that many training hospitals do not comply with rules such as post-call leave, a maximum of eight on-call shifts per month, and limiting on-call shifts to once every three days. This issue is explicitly mentioned in posts shared through the websites and mobile applications of TUS preparatory courses, based on resident physicians' own experiences regarding their training process.

The primary motivation for this study was to investigate why the Regulation, despite being a legal requirement, is not followed in many hospitals that offer residency training. TUEY aims to ensure that the training of resident physicians is conducted under more humane conditions, by reducing workload and providing a more effective training process. However, it has been observed that some department chairs and instructors in certain training hospitals do not comply with this Regulation.

Furthermore, within the scope of this study, the inspection mechanisms of the Ministry of Health and its stance on the non-implementation of the Regulation were evaluated. In this context, the researchers made a formal request to the Ministry of Health, asking for information about the hospitals not complying with the Regulation. In its response dated August 28, 2024, the Ministry stated the following [31]:

"Your application to the Presidential Communication Center has been examined. In accordance with the relevant legislation, the application must be submitted personally by the individual concerned, and the request will be considered upon fulfillment of this requirement."

Upon receiving this response, it was reiterated that the research was being conducted as part of a scientific study with ethical approval, and a second request was submitted. In its second response, dated October 18, 2024, the Ministry made the following statement [32]:

> *"As is known, the relevant procedures and processes concerning this matter are carried out within the framework of the Regulation on Specialty Training in Medicine and Dentistry (TUEY), the decisions of the Board of Medical Specialties (TUK) based on this legislation, and other related administrative regulations. In order for your request concerning your claims to be evaluated, you must submit a written application to the Ministry of Health."*

Both responses from the Ministry of Health show that the Regulation is not being implemented in the field and that inspection mechanisms are inadequate. The first response highlights the requirement for an individual application, indicating that no systematic investigation was initiated. The second response simply refers to existing legislation to address the issue and does not provide a concrete approach regarding how inspection and enforcement mechanisms operate. This situation demonstrates that, despite the Regulation, many hospitals continue their previous practices, and there is a lack of a monitoring process capable of fully protecting healthcare workers' rights.

This research has been shaped by the ongoing heavy working conditions of resident physicians and the failure to implement, in practice, the "Regulation on Specialty Training in Medicine and Dentistry," which entered into force on September 3, 2022. Despite the on-call limitations and training standards introduced by the Regulation, many hospitals have been found not to comply with these rules. The inadequacy of inspection mechanisms and the inability to protect the rights of healthcare workers constitute the central focus of this investigation.

Method

Study Design

A study conducted with resident physicians in training employed a phenomenological research method based on a naturalistic paradigm. A paradigm is a system of beliefs and values that includes the conceptual and theoretical framework aimed at explaining the research questions [33]. Naturalistic approaches seek to provide in-depth insight into the experiences of resident physicians during their training process. Phenomenological research is a methodology aimed at understanding how individuals experience a specific phenomenon [34]. It is used to explore emotional, psychological, and social processes. In this study, a phenomenological analysis [35] was chosen to gain a deep understanding of resident physicians' experiences regarding their working conditions, psychological impacts, pressure mechanisms, instructors' attitudes, and compliance with TUEY [36].

A qualitative content analysis approach is suitable for topics about which our current theoretical or practical knowledge is limited. In the literature concerning resident physicians' working conditions, there are limited studies on TUEY compliance, mobbing, and training processes. Therefore, a qualitative methodology was utilized to better understand the experiences of resident physicians and contribute to existing research. In the study, data were collected through semi-structured interviews and evaluated using a phenomenological analysis method. Data obtained from the participants were interpreted via thematic coding and content analysis, yielding meaningful findings related to the essence of the phenomenon [37].

Participants and Sampling

Resident physicians participating in the study were selected from 25 different medical faculties on a voluntary basis. The participants were identified among individuals whose training process was ongoing and who could provide relevant experience for the research topic. Thirteen of the resident physicians in the study were pursuing specialty training in internal medicine disciplines and were in the following departments: Emergency Medicine (n=2), Family Medicine (n=1), Pediatrics (n=2), Pulmonology (n=2), Internal Medicine (n=3), Cardiology (n=2), and Infectious Diseases and Clinical Microbiology (n=1). The other 12 resident physicians were continuing their specialty training in surgical medicine disciplines and were in the following departments: General Surgery (n=2), Anesthesiology and Reanimation (n=2), Obstetrics and Gynecology (n=2), Cardiovascular Surgery (n=2), Orthopedics and Traumatology (n=2), and Plastic, Reconstructive and Aesthetic Surgery (n=2). During the sampling process, the primary criteria included that participants were continuing their specialty training and were actively working in the relevant department.

Data Collection

When selecting the resident physicians to be interviewed, volunteers were chosen from the *"Nöbet Ertesi İzin"* (Leave After Duty) Telegram group, which consisted of physicians who were already registered. In addition, university administrations were contacted to identify resident physicians who would participate in the study. Furthermore, through managers of various sub-specialty courses, resident physicians in training were selected on a voluntary basis. In total, 60 resident physicians were contacted for the research; those who worked in the same department or university and knew each other were excluded from the sample. Interviews with resident physicians were conducted via their personal phones, outside of their workplace environment. The sample was chosen from resident physicians working in different departments at different universities. A minimum of one year of residency experience was set as a primary inclusion criterion. If there was more than one training hospital in the same province, only one training hospital was included in the sample.

Additionally, to examine the impact of different hospital structures and founding dates, a balance was established between hospitals with a longstanding history and those that were newly founded. Accordingly, one well-established training hospital founded in the 1950s and a relatively new training hospital founded in 2014 were included in the sample. Moreover, to represent different geographical regions of Turkey, at least one training hospital from the western, eastern, northern, and southern regions was selected. It was required that all included departments have mandatory on-call shifts so that the effects of the on-call system on the training process and working conditions could be analysed more accurately. In selecting the sample, factors such as the founding years of the hospitals, geographic distribution, and length of professional experience were considered, allowing for a comprehensive study that could compare differences in the training process. Also, to ensure gender balance among participants, an equal ratio of male and female participants was targeted.

Telephone interviews lasting approximately 25 to 45 minutes were conducted with the resident physicians, during which they were asked eight semi-structured questions (Table 1). Prior to the interviews, an ethics consent form was read to

the participants, and their informed consent was obtained. Throughout the research process, no personal information that could identify participants was requested, and full adherence to anonymity and confidentiality principles was maintained. Participants were coded as D1, D2, … D13 for internal medicine disciplines and C1, C2, … C12 for surgical disciplines. In addition, participants' ages, genders, the duration of their residency training, and the date and time of the survey as well as the interview duration were systematically recorded. Moreover, in accordance with the Personal Data Protection Law No. 6698 (KVKK), no audio recordings were taken, and responses given during the interviews were noted in writing. This method was chosen to protect participant privacy and ensure compliance with ethical principles. While allowing for the analysis of demographic and professional data, this approach also preserves participants' anonymity. Interviews continued until data saturation—i.e., "sampling to redundancy" [38]. In our study, data saturation was reached when no new concepts, categories, or dimensions emerged [38]. The interviewers attempted to minimize bias as much as possible by using various techniques such as bracketing, external checking, and keeping detailed records during both the interview process and data analysis.

Data Analysis

The data collection process was carried out concurrently using the inductive qualitative content analysis method developed by Elo and Kyngäs [39]. This method consists of three main phases: preparation, organization, and reporting. In the preparation phase, meaning units related to resident physicians' training processes were determined, and initial codes were created. By examining the interview records in detail, fundamental statements derived from resident physicians' experiences were analysed. In the organization phase, codes with similar meanings were grouped to form subcategories, and these relevant subcategories were classified into broader main categories. For example, codes such as "long working hours," "lack of training," and "heavy workload" were identified and then grouped under main categories like "working conditions," "challenges in training," and "psychological effects." In the reporting phase, the analysed data were organized to systematically present the difficulties encountered by resident physicians in their specialty training. The data analysis process was conducted using MAXQDA software, focusing on key issues such as the resident physicians' workload, quality of education, and psychological pressures. The data were analysed via an inductive content analysis method; after initial codes were formed, similar codes were brought together to create subcategories, which were then classified under main themes.

Trustworthiness

Four criteria suggested by Lincoln and Guba were applied to evaluate the trustworthiness of the study: credibility, dependability, conformability, and transferability [40]. To enhance the credibility of the data, triangulation was employed during the data collection and analysis process, prolonged engagement was maintained for six months, and maximum variation was sought in the sample. Additionally, member checking was used to assess the reliability of the codes; some of the developed codes were presented to the participants, and agreement between the researchers and participants was evaluated. To ensure the dependability of the data analysis process, a portion of the interview transcripts along with the resulting codes and categories were sent to two independent external auditors, and the analysis process was confirmed. Finally, transferability of the study was supported by providing rich and detailed descriptions [40, 41].

Results

The participants consisted of 14 women and 11 men. The demographic characteristics of the participants are summarized in Table 1. The content analysis was evaluated in four main categories: "On-Call Scheduling and (TUEY) Practices," "Residents' Psychological and Emotional State," "Roles of Those in Charge and Pressure Mechanisms," and "Instructors' Psychological Pressure and Proposed Solutions." Table 2 presents them in "Main Categories," "Categories," and "Subcategories."

Table 1. Demographic Characteristics of the Participants

Participants	Value
Gender	14 women, 11 men
Age	27 to 46
Average Duration of Work	3 years
Departments	Internal Medicine (13) • *Emergency Medicine (2)* • *Family Medicine (1)* • *Pediatrics (2)* • *Pulmonology (2)* • *Internal Medicine (3)* • *Cardiology (2)* • *Infectious Diseases and Clinical Microbiology (1)* Surgery (12) • *Anesthesiology and Reanimation (2)* • *General Surgery (2)* • *Obstetrics and Gynecology (2)* • *Cardiovascular Surgery (2)* • *Orthopedics and Traumatology (2)* • *Plastic, Reconstructive and Aesthetic Surgery (2)*

1. "On-Call Scheduling and (TUEY) Practices"

Most participants stated that although there were delays after TUEY came into force, the rule of having a maximum of eight on-call shifts per month was observed. Nevertheless, many participants noted that the post-call day-off rule was not implemented.

1.1. "Monthly On-Call Schedule"

Of the 25 resident physicians participating in the study, 21 indicated that the rule of a maximum of eight on-call shifts per month was followed. Four, however, stated that the limit of eight on-call shifts per month was not respected. Although there was initial resistance to the monthly on-call limit, TUEY's rule in this regard was mostly complied with after two months.

In this context, participants stated the following:

"After TUEY was introduced, the rule of eight shifts per month was followed. At first, some instructors resisted, but within two months, the department fully adapted to this regulation." (D1).

"As soon as TUEY was released, it was put into practice in our department." (C1).

"The on-call rule in TUEY is definitely not enforced; shifts are scheduled entirely at the instructors' discretion. When I asked why it was not being implemented, the department head threatened me with withholding my qualification." (C2).

they're not following the regulation; we work 10 shifts, yet we only receive pay for 8." (C7).

"The rule of eight shifts per month is only on paper and not actually enforced. Because there are not enough residents in the department, we constantly have to take additional shifts." (D12).

1.2. "Post-Call Work"

One of the issues the resident physicians complained about was the day-off following an on-call shift. Even though TUEY explicitly states that it is strictly prohibited for a resident who has worked 24 hours (including the night shift) to be required to continue providing healthcare services the following day, many departments show strong resistance to this rule. Sixteen of the 25 participants noted that a post-call day-off was not granted for various reasons.

In this regard, participants stated:

"After a 24-hour on-call shift, some instructors force us to stay for rounds. Morning rounds sometimes last until noon, so we cannot leave the hospital. When we object, we are subjected to bullying by the instructors." (D1)

"While working in the ward, we are forced by our instructors to attend rounds after our shift. We are also expected to give case presentations or lectures at midday, post-shift." (D3)

"Our instructors strongly oppose granting a day-off after a shift; some of them practically want us to live in the hospital. Under the pretext of 'education,' they try to do away with our post-call breaks." (D4)

"I continue working even after my shift, effectively working 36 hours straight just like before the law. Moreover, I don't get compensated for these extra hours." (C2)

"For six months after the law was passed, no post-call day-off was given; our department head made it mandatory for us to stay until noon. Later, they started granting a post-call day-off, but only if we attended rounds." (D6)

"Because we are in a training and research hospital in eastern Turkey, there are not enough residents, and we work 36 hours straight on-call. When we don't continue working after our shift, our instructors insult and belittle us and even threaten to remove us from the training program." (D9)

"We don't work after our shift; the on-call resident signs off at 7 or 8 in the morning and leaves the hospital." (C3)

2. "Residents' Psychological and Emotional State"

With the decrease in academic staff, the structure of residency duties has come to serve more as an intermediary workforce for ensuring the continuity of hospital operations rather than focusing on education. In Turkey, after six years of medical education, physicians work in numerous fields such as emergency medicine or family medicine. That means the candidate who enters residency training through an examination is, in fact, already a physician. They hold the same status as an instructor who has an academic title or a specific specialty. While much is said about the working environment of physicians, doctors who resign or commit suicide due to workplace conditions are often forgotten. Most of the doctors who participated in our study reported that their psychological well-being had been severely compromised due to heavy and stressful workloads.

Table 2. Systematic Exploitation in Residency Programs and (TUEY) Practices

Main Categories	Categories	Subcategories
1. On-Call Scheduling and (TUEY) Practices	1.1. Monthly On-Call Schedule	1a. Are the provisions of (TUEY) that limit the monthly number of on-call shifts to eight being followed? If not, how does this affect you?
	1.2. Post-Call Work	1b. Have you experienced pressure to continue working after your on-call shift? How did you feel this pressure, and how did you respond to it?
2. Residents' Psychological and Emotional State	2.1. Excessive Workload, On-Call Hours, and Psychological Effects	2a. Do you believe that excessive workload and long on-call hours cause stress, burnout, or emotional exhaustion?
	2.2. Decision-Making Under Pressure	2b. Have you been in situations where you had to make decisions under pressure due to an intense pace of work and fatigue? How did those situations make you feel?
3. Roles of Those in Charge and Pressure Mechanisms	3.1. On-Call Scheduling, (TUEY) Compliance, and Lack of Oversight	3a. Do you think department heads are sufficiently attentive to scheduling on-call shifts and adhering to (TUEY)? If not, why do you think this is the case?
	3.2. Pressure from Supervisors Regarding Workload and On-Call Requirements	3b. Have you felt pressured by those in charge regarding workload or on-call requirements? How did you experience this pressure, and how did you cope with it?
4. Instructors' Psychological Pressure and Proposed Solutions	4.1. Insults, Belittlement, and Professional Self-Confidence	4a. Have you frequently encountered insults, insinuations of incompetence, or belittling remarks from instructors? How have such psychological pressures affected your professional self-confidence, motivation, and performance?
	4.2. Effective Use of (TUEY) and Proposed Solutions	4b. What steps can be taken to reduce such oppressive attitudes among instructors and create a healthier working environment? What are your recommendations for effectively using (TUEY) in this context?

Excessive Workload, On-Call Hours, and Psychological Effects”

Excessive workload and intense on-call hours rank among the most significant problems that lower the living standards of resident physicians and reduce their commitment to the profession. In busy departments, having residents shoulder all responsibilities as a means of sustaining operations has become part of the excessive workload. Sixteen participants mentioned that the excessive workload and intensity of on-call shifts had very negative effects on their psychological well-being.

In this context, participants stated the following:

“Because of the insufficient number of academic staff, I spent 14 months in the endocrinology ward and 12 months in the nephrology ward. Since there are two main sections in the internal medicine department, I had to receive my training in this way. I did not rotate through gastroenterology, rheumatology, hematology, or medical oncology. When I requested these rotations, my department head scolded me, saying ‘What are you going to learn in those areas?’ I’m struggling with an excessive workload in these busy departments. I’ll graduate with insufficient training, and my psychological well-being has deteriorated to a point where I feel helpless.” (D13)

“The instructors have a very negative attitude toward female residents. I got into this department by ranking highly in the Medical Specialty Examination (TUS). When I started working, my department head made a harshly sexist remark, saying ‘We don’t want female residents.’ They gave me all the workload. I can’t leave the ward. My department head did everything possible to force me to leave the department.” (C9)

“There’s a huge amount of work and stress. There are only three of us in the internal medicine department, and we constantly work under excessive workload because no new residents are coming in. This situation has completely eliminated my family life and communication.” (C7)

“The stress level is at its highest; I have to attend to 3–4 different places simultaneously. I am the one who handles consultations, the ward, and the emergency department. By the time I leave the hospital, I feel extremely worn out.” (C6)

“I take eight on-call shifts a month, and I can only go home around two o’clock after each shift. When I get home, I sleep, so I don’t see my child or my spouse. My child has been crying, saying, ‘When will my dad come home?’ Hearing that made me start to hate my job.” (D10)

“I constantly feel burned out; my private life is basically gone. My spouse was also working as a resident in another institution, and they had to resign because of these reasons.” (D8)

“Sure, it’s difficult at first, but as you gain seniority, it becomes much more manageable over time.” (C3)

2.2. “Decision-Making Under Pressure”

Especially during on-call shifts, resident physicians frequently find themselves in situations where they have to make decisions under pressure. Eighteen participants stated that they made many decisions under duress.

In this regard, participants stated:

“In every on-call shift, when I can’t reach our instructors, I’m constantly stressed about whether I’m making the right decision. It’s the same for the other two residents in our department.” (C7)

“There’s no one to consult during on-call shifts. It’s difficult even to call the instructor; either they don’t answer the phone, or if they do, they respond by saying, ‘Can’t you handle a single task?’” (D10)

“I’m working excessively; I had to take a shift every other day just to be able to go on a summer vacation. Actually, according to the 2022 regulation, taking a shift before three days have passed is prohibited, but I had to do it to get one week of annual leave. The workload was so heavy that sometimes I wasn’t even aware of what I was doing. Situations like this, caused by fatigue, make it even harder to make decisions under pressure and lead you to make mistakes.” (D6)

“Our medical faculty was established in a rural area and has a regional hospital status, so it’s extremely busy. The instructors, wanting to reduce their own workload, put a lot of work on us. Because I’m inexperienced, I’m forced to work under a great deal of pressure out of fear of the instructors.” (C11)

“This situation happens in almost every on-call shift. If there isn’t a senior resident on shift or if there’s no one else in the ward, you can’t call the instructor; even if you do, they won’t pick up. So you have to make critical decisions yourself. And if you make a mistake, it’s inevitable that you’ll be insulted at the next round.” (D7)

“A hectic pace of work has become part of our residency. The moment you make a mistake, you face a lot of backlash from the instructors, and there’s nothing you can do except cry.” (D4)

“It happens very rarely. Usually, senior residents protect us from this stressful environment.” (D2)

3. Roles of Those in Charge and Pressure Mechanisms

Many teaching hospitals at medical faculties do not adhere to the structure stated in the training regulations, which specifies that “training must be provided in accordance with the curriculum and standards, and the institution must provide the infrastructure that meets educational and social needs.” In particular, these curricula and standards are highly disorganized in rural hospitals.

3.1. “On-Call Scheduling, (TUEY) Compliance, and Lack of Oversight”

Sixteen of the participating resident physicians indicated that the structure of “providing training in accordance with the curriculum and standards” specified in TUEY was not followed.

In this context, participants stated the following:

“Whatever the instructors say goes. Sometimes they assign shifts for the entire weekend, so I can’t spend any time alone with my family. During my cardiology rotation, they scheduled three on-call shifts for me, but not only did they deny me a post-call day off, they also didn’t pay me for the shift.” (D4)

“They are definitely not sensitive about it. Since our department admits residents with a much lower examination score compared to other medical faculties, the incoming residents are forced to accept violations of on-call rules. In fact, I haven’t even been paid for working post-call shifts.” (C2)

“Their primary goal is to keep things running, and department heads don’t really care about the rest. I learned more when I was working as a general practitioner in the emergency department before I started my specialty training. Now I’m an emergency resident, but I barely receive any training from the instructors.” (D5)

“They are absolutely not sensitive about this, and in any case, it’s impossible to maintain such a situation. Somebody has to be on duty in the ward, and since the

Multiple instructors can't stay, it inevitably falls on the residents. If there are only two residents in the department, each one is assigned eight shifts. For the remaining 14 days, interns remain in the ward, but even if those two residents are at home, they have to answer calls from the interns. So on paper, it looks like eight shifts, but in reality, it's 15." (C6)

"Everything remains on paper. The instructors continually try to circumvent the regulation by assigning more workload." (C4)

"Our instructors are very sensitive about this issue. Even before the on-call regulation was introduced, our department was already famous for allowing both post-call days off and having a low monthly number of on-call shifts. For that reason, many residents choose us despite it being a general surgery department, which is considered a difficult specialty." (C5)

3.2. "Pressure from Those in Charge Regarding Workload and On-Call Shifts"

Eighteen of the participating residents mentioned that there were problems in this area, particularly complaining about the excessive workload per resident.

In this context, participants stated the following:

"There's constant pressure. Sometimes there are 20 patients and 2 instructors, but they keep admitting patients, and sometimes only one resident is responsible for 35–40 patients. That's too many for one resident to manage. Handling so many patients on-call, then joining the morning rounds and taking notes on what was done, writing the treatments—this all means the resident cannot leave the hospital." (D6)

"I have never felt any pressure. Our instructors do everything they can to make a positive contribution to our training process." (C12)

"The on-call shifts are not relaxed; aside from the ward duties, you get constantly called from the emergency department." (C10)

"We only get warnings about leaving our shift, which is the way it should be." (C8)

4. Instructors' Psychological Pressure and Proposed Solutions

Under this main heading, a very different structure emerges. In departments where the number of residents is high, there tends to be no psychological pressure from instructors because the hierarchy does not bring the resident physician and the instructor directly into conflict. However, in departments where the residency program has been newly established and there are relatively few residents, it is clearly evident that instructors attempt to exert verbal pressure on residents. One observed way of coping with the heavy patient load is to place verbal pressure on the resident. Additionally, participants emphasize the importance of Ministry of Health inspections in solving these problems in residency training.

4.1. Insult, Belittling, and Professional Self-Confidence

Nineteen out of 25 participants stated that they had experienced insults and belittlement, amounting to mobbing, from their instructors.

In this context, participants stated the following:

"It is done systematically. The medical faculty is located in a small city, and because my department head comes from an influential family in this town, I have to tolerate every insult." (C2)

"This situation is very common at the hospital where I work. Many of the professors there have faced inquiries about this, but nothing ever comes of it. In the department, the attitude is basically 'Let's not do anything about it,' because there are very few faculty members." (D6)

"I am belittled because of my age, as most of my instructors are younger than me. I even hear comments like, 'Do they take assistant at this age?' There are even academics who say the department has turned into a 'nursing home.'" (D7).

"Some of our instructors basically use us as their secretaries in outpatient clinics. We feel less valued than their actual secretaries. They have us make coffee for them, bring them tea, and so on." (D8)

"Most of our professors lack proper training, and they try to mask their inadequacies by constantly asking questions. Of course, they do this by insulting us. Our instructors have no academic experience at all." (D10).

"The way our instructors treat us is very good. They say to us, 'You are valuable residents of a well-established medical faculty.' Hearing this makes us very proud." (C8).

4.2. Effective Use of (TUEY) and Proposed Solutions

When it comes to resolving the issues that residents face during their training, the emerging consensus is that the Ministry of Health should take steps to increase oversight. Many participants believe that this problem can only be solved through ministry inspections. While 15 participants stated that they believe the problems in training can be resolved, 10 indicated that they think a solution is impossible or extremely difficult.

In this regard, participants stated the following:

"Ministry oversight is very weak; training and research hospitals allow instructors to engage in all kinds of illegal activities." (D6).

"Unions and health-related non-governmental organizations do not give this issue the attention it deserves. They see it as a temporary problem and thus do not care. Residency training should be subject to strict monitoring by the Ministry of Health." (D7).

"There is no hierarchy in our medical faculty; our dean comes to the city where the medical faculty is located once a week. Instructors act entirely on their own, behaving purely as specialist physicians. It's impossible to oversee this." (D13).

"All the academics here have psychological issues, and they project these onto us. We have instructors who belong in a psychiatric hospital giving us our training. The hospital management turns a blind eye. Because it's a specific surgical department, the hospital management ignores their unlawful actions for the sake of profit. Only the ministry can inspect this. The Ministry must urgently send inspectors. Torturing residents does not equate to good training." (C11).

"Once they become professors, medical faculty instructors gain enormous power. The university administration overlooks the mistakes of these professors to prevent them from leaving, thereby allowing them to do as they please. Hence, the problems related to residency training cannot be fixed." (C1).

"There are many inadequate academics in state-affiliated medical faculties. Most of the problems in resident training stem from these instructors. Many of them are bolstered by political affiliations, and TUEY doesn't affect them." (D4).

Discussion

This study aims to reveal the applicability of the (TUEY) dated September 3, 2022, in medical faculties and the challenges faced by resident physicians. In this context, it provides a qualitative analysis to understand the difficulties of the residency education system. In fact, everyone is aware of the problem. The President of the largest Physicians' Union in Turkey expressed the existing problem as follows [42]:

"Our resident physicians, who ensure the future of our profession and the guarantee of our healthcare, are forced to struggle with many issues such as pressure and difficulties in education. Primarily, education should not be left behind health service delivery, but unfortunately, the quality of education has dropped significantly. Education should be standardized for all resident physicians under equal conditions. As part of their training, our resident physicians should be sent to domestic and international conferences twice a year, and these costs should be covered by the administrations. The differences in base pay and incentive bonuses among our resident physicians must be resolved. Post-call days off are not being granted under various excuses such as education and duties. The regulation is very clear on this. Post-call days off must be granted immediately. Furthermore, on-call wages are underpaid. In fact, they illegally assign on-call duties without paying for them. Other significant problems include unlawful assignments, such as sending resident physicians to the emergency department, and the pressure exerted upon them."

The findings of this research provide striking results showing that specialty training in medicine is not merely a process of acquiring professional competence but also a period that tests psychological and physical resilience.

1. Implementation Issues of the Regulation: The research findings reveal that those responsible for training attempt different means of applying the regulation, often not implementing it at all. According to participating residents, while the rule of a maximum of eight on-call shifts per month is largely followed, post-call days off are generally not granted. The primary reason for this appears to be that department heads and instructors continue to keep residents under active workload due to staff shortages. This situation transforms specialty training into a period of intense physical and mental strain rather than a process of professional development.

2. Psychological and Emotional Strain: Resident physicians are under severe psychological pressure due to heavy workloads, long working hours, and the on-call system. (TUEY) does not contain any particular regulation regarding this. The majority of participants reported feeling burnout, loss of motivation, and difficulty coping with stress. This psychological and emotional strain was more frequently expressed by residents working in newly established training institutions where a culture of residency education has not yet formed.

3. Pressure from Those in Charge and Lack of Oversight: The data show that hospital administrations and department heads do not demonstrate sufficient sensitivity to implementing (TUEY). In some departments, residents continue to be assigned duties outside their normal working hours; although the on-call limit is officially set at eight shifts, in practice, this number is exceeded. Because the law stipulates that no additional payment is made for more than eight shifts and that residents are officially on leave after shifts, extra hours worked and pay for additional shifts are not compensated. The lack of oversight mechanisms allows these violations to continue. Participants indicated that this issue can only be resolved through independent oversight mechanisms and stricter interventions.

4. Mobbing and Academic Pressure: Another significant problem during specialty training is the verbal harassment, insults, and professional belittlement that residents experience from instructors. This situation leads to the deterioration of some residents' psychological well-being and even to them becoming disillusioned with the profession. Residents in newly established training hospitals reported being psychologically pressured by instructors. Participants indicated that instructors use pressure as a tool of authority. Not only does this lower the quality of education, but it also causes some physicians to leave the profession prematurely.

Conclusion

Resident physicians undergoing specialty training face serious structural problems. The failure to implement (TUEY) in practice, psychological pressure, long working hours, and lack of oversight are among the greatest challenges in residency training. In order to resolve these issues, the following recommendations are presented:

- Independent Oversight Mechanisms: The working conditions of resident physicians must be continuously monitored, and violations must be identified. It is also important to establish an inspection team composed of doctors. The Board of Medical Specialties (TUK) should be transformed into a more recognizable entity. There must be a TUK representative in educational institutions, and this representative should be directly affiliated with the Ministry of Health.
- Ethical and Pedagogical Training for Instructors: To prevent psychological pressure on residents, instructors should be required to undergo ethical training. In particular, a course on work ethics must be included in medical education.
- Legal Measures to Protect Residents' Rights: Independent mechanisms should be established that provide legal support for resident physicians facing rights violations and mobbing. Labor unions must place greater emphasis on this issue.
- Addressing Staff Shortages: In order to reduce resident physicians' working hours, an adequate number of specialist physicians must be provided. Departments should not be permitted to offer residency training if they fall below a certain number of residents, or positive discrimination measures should be taken for departments with few residents.

In conclusion, addressing the difficulties faced by resident physicians during their specialty training is a critical step that will enhance the quality of both medical education and healthcare services.

References

1. Sayer M, Chaput de Saintonge M, Evans D, Wood D. Support for students with academic difficulties. *Med Educ.* 2002 Jul;36(7):643–50.
2. Yükseköğretim Kurulu (YÖK). YÖK Atlas [Internet]. 2024 [cited 2025 Jan 20]. Available from: https://yokatlas.yok.gov.tr/netler-tablo.php?b=10206
3. Diniz G, Başer A, Yılmaz D, Kayahan E, Sonay Bolat S, Bıtrak FS, et al. Tıp Fakültelerinin Tıpta Uzmanlık Sınavı Başarısına İlişkin Özellikleri. *İzmir Demokrasi Üniversitesi Sağlık Bilimleri Dergisi.* 2023:423–34. doi:10.52538/iduhes.1284281
4. Kaya RR, Alkan A. Türkiye'deki kamu hastanelerinde idari pozisyonda görev yapan hekimlerin profillerine yönelik bir çalışma. *CBU-SBED.* 2021;8(2):254–62. doi:10.34087/cbusbed.799117
5. Ölçme, Seçme ve Yerleştirme Merkezi (ÖSYM). TUS: Tıpta Uzmanlık Eğitimi Giriş Sınavı [Internet]. 2024 [cited 2025 Jan 24]. Available from: https://www.osym.gov.tr/TR,29136/2024.html
6. Cansever İH, Metin A, Kişi M. Tıp öğrencilerinin tıpta uzmanlık tercihlerini etkileyen faktörler üzerine sistematik derleme. *OPUS Uluslararası Toplum Araştırmaları Dergisi.* 2020;16(27):791–812. doi:10.26466/opus.646193
7. Çıtıl R, Keten M. Tıp fakültesi öğrencilerinin uzmanlık tercihleri ve mesleki kaygı düzeyleri. *Gaziosmanpaşa Üniversitesi Tıp Fakültesi Dergisi.* 2021;13(3):171–92.
8. Balcı Yapalak AN, Uçar A, Yüce S, Ataç Ö. Tıpta uzmanlık seçimini etkileyen faktörlerin değerlendirilmesi. *İstanbul Tıp Fakültesi Dergisi.* 2021;84(1):120–9. doi:10.26650/IUITFD.2019.0062
9. Organisation for Economic Co-operation and Development (OECD). Doctors (Practising Physicians), total, per 1,000 inhabitants, 2024 [Internet]. OECD Health Statistics; 2024 [cited 2025 Jan 25]. Available from: https://stats.oecd.org
10. Ölçme, Seçme ve Yerleştirme Merkezi (ÖSYM). 2024-TUS 2. Dönem Ek Tercih Kılavuzu – Boş Kontenjanlar Tablosu [Internet]. Ankara: ÖSYM; 2024 [cited 2025 Jan 25]. Available from: https://dokuman.osym.gov.tr/pdfdokuman/2024/TUSDONEM-2/TERCIH/EK/konttablo_tsed05122024.pdf1
11. Evrensel Gazetesi. TUS'ta kontenjanlar yine boş kaldı: Çocuklarımıza bakacak doktor bulamayacağız [Internet]. 2024 Jun 4 [cited 2025 Jan 25]. Available from: https://www.evrensel.net/haber/520135/tusta-kontenjanlar-yine-bos-kaldi-cocuklarimiza-bakacak-doktor-bulamayacagiz
12. Yılmaz Y, Uçar E, Ertin H. Tıpta Uzmanlık Eğitimi ve Asistan Hekimlerin Sorunlarının İrdelenmesi: Bir Anket Çalışması. *Tıp Eğitimi Dünyası.* 2019 Apr 30;18(54):21–9. doi:10.25282/ted.431136
13. Dikmetaş E, Top M, Ergin G. Asistan hekimlerin tükenmişlik ve mobbing düzeylerinin incelenmesi. *Turk Psikiyatri Derg.* 2011;22(3):137–49.
14. Lüleci E, Keskin Y, Asan S, Acar Ö, Değirmenci F, Karadayı S, et al. Marmara Üniversitesi Tıp Fakültesi asistanlarında mobbing psikolojik şiddet algısı. *Maltepe Tıp Derg.* 2011.
15. Tüfekçi M. Acil tıp uzmanlık öğrencilerinde mobbing algı düzeylerinin incelenmesi. Mersin Üniversitesi; 2014.
16. Yavaşcaoğlu B, Aydın B, Karataş EG, Kaya FN, Özcan B, Kırlı S. Anestezi asistanlarında nöbetin bilişsel işlevler ve ruhsal durum üzerine etkisi. *Uludağ Üniversitesi Tıp Fakültesi Dergisi.* 2007;33(2):75–9.
17. Özaydın Bülbül P, Ünal E, Bozaykut T, Korkmaz M, Yücel AS. Sağlık çalışanlarında mobbing: Kamu ve özel sağlık kurum çalışanlarının karşılaştırmalı Türkiye örneği. *Uluslararası Hakemli Akademik Spor Sağlık ve Tıp Bilimleri Dergisi.* 2013.
18. Korkut Y, Müderrisoğlu S, Tanık M. Klinik Psikoloji Alanında Karşılaşılan Etik İhlal Örnekleri ve Nasıl Ele Alındıklarının Değerlendirilmesi. *Türk Psikoloji Yazıları.* 2006;9(18):49–61.
19. Kehribar A, Karabela ŞN, Yaşar KK, Okur A, Derya M, Özgür C, et al. Çalışma hayatında mobbing: nedenleri, bileşenleri ve ülkemizdeki hukuki durumu. *BTD MJB.* 2017;17(3):101. doi:10.5350/BTDMJB201713101
20. Türk Tabipleri Birliği. Asistan Hekimin Hakları Var. Ankara: Türk Tabipleri Birliği; 2021 Jul.
21. Asistan ve Genç Uzman Hekimler. SÜ Tıp Fakültesi'nde haklarını arayan asistan hekimlerin yanındayız [Internet]. 2023 Jul 27 [cited 2025 Jan 25]. Available from: https://asistanhekim.org/su-tip-fakultesinde-haklarini-arayan-asistan-hekimlerin-yanindayiz
22. Mobbing ile Mücadele Derneği. Asistan doktorların isyanı: Tükeniyoruz [Internet]. [cited 2025 Jan 25]. Available from: https://www.mobbing.org.tr/asistan-doktorlarin-isyan-tukeniyoruz
23. Türkiye Barolar Birliği. TBB'den "Tüm Yönleriyle Mobbing" Sempozyumu [Internet]. 2020 Feb 12 [cited 2025 Jan 25]. Available from: https://www.barobirlik.org.tr/Haberler/tbb-den-tum-yonleriyle-mobbing-sempozyumu-81119
24. Akan AK. Ankara Şehir Hastanesinden trafik kazasında vefat eden doktorla ilgili açıklama. *Anadolu Ajansı* [Internet]. 2021 Oct 25 [cited 2025 Jan 25]. Available from: https://www.aa.com.tr/tr/gundem/ankara-sehir-hastanesinden-trafik-kazasinda-vefat-eden-doktorla-ilgili-aciklama/2402221
25. Uluslararası İşçi Dayanışması Derneği. Yorgun doktorlar ölüyor, 36 saat nöbet olmaz! [Internet]. [cited 2025 Jan 25]. Available from: https://uidder.org/yorgun_doktorlar_oluyor_36_saat_nobet_olmaz.htm
26. Dikmetaş E, Top M, Ergin G. Asistan hekimlerin tükenmişlik ve mobbing düzeylerinin incelenmesi. *Turk Psikiyatri Derg.* 2011;22(3):137–49.
27. Öz E. Asistan hekimler yaşadıkları mağduriyetleri anlattı ve çözüm önerileri sundu. *Independent Türkçe* [Internet]. 2021 Oct 28 [cited 2025 Jan 25]. Available from: https://www.indyturk.com
28. Türkiye Cumhuriyeti Resmî Gazete. Tıpta ve diş hekimliğinde uzmanlık eğitimi yönetmeliği. *Resmî Gazete* [Internet]. 2022 Sep 3 [cited 2025 Jan 25];(31942). Available from: https://www.resmigazete.gov.tr
29. TusKocu. Nöbet ertesi izin yönetmeliğine uymayan hastaneler [Internet]. 2023 Jan 18 [cited 2024 Mar

25]. Available from: https://tuskocu.com/nobet-ertesi-izin-olmayan-hastaneler/
30. Proders Yazılım Eğitim Bilişim Hizmetleri Tic. ve San. Ltd. Şti. TUSBuddy Mobil Uygulama Arayüzü [Internet]. Ankara: Proders Bilişim; 2024 [cited 2025 Jan 26]. Available from: https://www.tusbuddy.com
31. Cumhurbaşkanlığı İletişim Merkezi (CİMER). 2402978074 sayılı başvuruya verilen yanıt [Internet]. Ankara: CİMER; 2024 Aug 26 [cited 2025 Jan 26]. Available from: https://www.cimer.gov.tr
32. Cumhurbaşkanlığı İletişim Merkezi (CİMER). 2403621838 sayılı başvuruya verilen yanıt [Internet]. Ankara: CİMER; 2024 Oct 18 [cited 2025 Jan 26]. Available from: https://www.cimer.gov.tr
33. Cypress B. Qualitative research methods: a phenomenological focus. *Dimens Crit Care Nurs.* 2018;37(6):302–9.
34. Muzari T, Shava GN, Shonhiwa S. Qualitative research paradigm, a key research design for educational researchers, processes and procedures: A theoretical overview. *Indiana J Humanit Soc Sci.* 2022;3(1):14–20.
35. Ho KH, Chiang VC, Leung D. Hermeneutic phenomenological analysis: The 'possibility' beyond 'actuality' in thematic analysis. *J Adv Nurs.* 2017;73(7):1757–66.
36. Eatough V, Smith JA. Interpretative phenomenological analysis. In: *The Sage Handbook of Qualitative Research in Psychology.* 2017. p. 193–209.
37. Tuffour I. A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *J Healthc Commun.* 2017;2(4):52.
38. Holloway I, Galvin K. *Qualitative research in nursing and healthcare: (Chapter 18).* Wiley; 2016.
39. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs.* 2008;62(1):107–15. doi:10.1111/j.1365-2648.2007.04569.x
40. Speziale HS, Streubert HJ, Carpenter DR. *Qualitative research in nursing: Advancing the humanistic imperative.* Lippincott Williams & Wilkins; 2011.
41. Holloway I, Galvin K. *Qualitative research in nursing and healthcare: (Chapter 18).* Wiley; 2016.
42. Hekim Birliği. [Reel about healthcare]. Instagram [Internet]. [cited 2025 Jan 28]. Available from: https://www.instagram.com/hekimbirligi/reel/C_AMT4OoZ11/