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An examination of the relationships between organizational support, trust, identification, and commitment among disabled healthcare workers employed in public hospitals in Turkey

Ulku Turkugur[1], Mevlut Karadag[2*], Ismet Sahin[2] and Bayram Sahin[2]

*Correspondence:
Mevlut Karadag
mevlut.karadag@lokmanhekim.edu.tr
[1]Vocational School of Health Services, Health Sciences University, Ankara, Turkey
[2]Vocational School of Health Services, Lokman Hekim University, Ankara, Turkey

Abstract

Objective Disabled healthcare workers represent an underrepresented segment of the health workforce and may experience organizational life differently because of structural and psychosocial barriers. This study examined the associations among perceived organizational support, organizational trust, organizational identification, and organizational commitment in disabled healthcare workers employed in public hospitals in Türkiye, and exploratory analyses considered whether selected associations varied by disability degree.

Methods A cross-sectional study was conducted on 316 disabled healthcare professionals working in 15 public hospitals in Ankara between November 2023 and February 2024. Data were collected using a survey method. The structural validity of the scales used in the research was examined with confirmatory factor analysis, their reliability with the internal consistency coefficient, and the relationships between variables with structural equation modeling. We also tested whether disability degree moderated selected associations in the model to assess whether the classic support–trust–identification–commitment framework operates uniformly within this marginalized workforce.

Results Perceived organizational support was positively associated with organizational trust ($p<.001$; $\beta=0.808$) and organizational commitment ($p=.012$; $\beta=0.258$), while organizational trust was positively associated with organizational identification ($p<.001$; $\beta=0.774$) and organizational commitment ($p=.016$; $\beta=0.322$). Perceived organizational support was not significantly directly associated with organizational identification, but its indirect association via trust was significant. Moderation analysis indicated that disability degree moderated selected associations, particularly the relationship between organizational trust and organizational commitment.

Conclusion The findings were broadly consistent with the relevance of supportive and trust-related organizational experiences for disabled healthcare workers in public hospitals. However, because the study was cross-sectional, self-reported, and showed

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substantial shared method variance, the results should be interpreted cautiously and as associative rather than causal.

Keywords Disabled healthcare professionals, Organizational support, Organizational trust, Organizational identification, Organizational commitment, Turkey

1 Introduction

Disability is a globally significant issue in the areas of equality, inclusion, and sustainability in the world of work. Individuals with disabilities face multifaceted obstacles in their workforce participation processes, including lack of physical accessibility, inadequate adapted working conditions, lack of organizational support, and discriminatory attitudes [1]. This situation not only limits individuals' employment opportunities but also directly impacts organizations' human resources policies, productivity, and social equality goals.

The healthcare sector is a work environment that requires intense human interaction and involves high workloads and stress levels; therefore, employees with disabilities need more organizational support in terms of both job adaptation and retention [2]. International literature shows that the employment of individuals with disabilities provides significant benefits not only in the context of social justice and human rights, but also in terms of organizational sustainability and performance [3, 4].

In Turkey, an amendment to Article 53 of the Civil Servants Law No. 657 mandated the employment of disabled individuals in both the public and private sectors. This amendment made it compulsory for private sector companies with more than fifty employees to employ 3% disabled individuals, and for public institutions and organizations to employ 4%, thus facilitating their participation in the workforce. Despite these regulations, disabled employees continue to face obstacles and discrimination in the labor market related to social exclusion; physical and spatial accessibility; job design and human resources processes; corporate policies; lack of support; promotion and wage structures; legal and administrative practice gaps; and accessibility to information and communication [5, 6, 7]. These challenges directly affect not only the psychosocial well-being of employees but also their organizational attitudes and behaviors. Therefore, understanding the mechanisms that determine the relationship between disabled healthcare workers and the organization is crucial for both improving employee welfare and developing more inclusive policies in the human resources management of organizations.

In the organizational behavior literature, perceived organizational support, organizational trust, organizational commitment, and organizational identification stand out as key factors in understanding employee behavior. Perceived organizational support refers to an employee's perception that they are valued by the organization and that their well-being is considered important [8]. Employees who feel supported by their organizations tend to develop commitment and trust in the organization due to the principle of reciprocity [9]. Research indicates that working conditions and perceived organizational support among employees with disabilities are associated with key work attitudes—particularly organizational commitment—and that perceived organizational support can strengthen organizational identification processes that are closely linked to commitment [10–14]. Furthermore, organizational support appears to affect not only job performance and organizational citizenship behaviors, but also employees' burnout levels and intentions to leave [15].

Organizational trust encompasses employees' beliefs that the organization is fair, consistent, and predictable. The literature states that organizational trust is a fundamental psychosocial process that shapes employees' positive attitudes towards the organization [16]. Mayer, Davis, and Schoorman's (1995) model emphasizes that trust has both cognitive and emotional dimensions in intra-organizational relationships and demonstrates that trust is a significant determinant of organizational commitment and identification [17]. Employees develop higher commitment and stronger belonging in organizations with a strong trusting environment [18, 19].

Organizational identification is a concept based on social identity theory that describes an individual's psychological integration with their organization [20]. It expresses the level at which an individual perceives themselves as part of the organization, and various studies have reported that a supportive organizational climate increases the sense of belonging [13]. Employees with high levels of identification view their organization's successes as their own and make stronger contributions to organizational goals.

Organizational commitment refers to an individual's emotional connection to their organization, their adoption of the organization's values, and their desire to remain within the organization [9, 44]. Meta-analysis findings show that organizational commitment (especially emotional commitment) is negatively correlated with intention to leave and actual leaving, while it is positively correlated with outcomes such as attendance/participation, performance, and organizational citizenship behavior [21, 22]. Furthermore, another performance-focused study reports a significant positive correlation between attitudinal organizational commitment and job performance [23].

Recent studies indicate that organizational support and trust-based or inclusive managerial relations are associated with improved job satisfaction, workplace experiences, and performance-related outcomes among employees with disabilities [11, 24, 25]. Access to workplace social support and structural accommodation mechanisms (e.g., accessibility arrangements, job redesign, flexibility, and assistive tools) is consistently associated with more sustainable employment outcomes for employees with disabilities, including maintaining employment and reducing exit intentions [26–28, 43]. Evidence from Türkiye also highlights that accessibility and workplace conditions are central to labor-market integration, and that negative workplace experiences undermine job satisfaction and increase the intention to leave among employees with disabilities [27, 29]. In the healthcare sector, disability-focused research shows that accommodations are linked with improved job satisfaction for healthcare workers with disabilities [30], while reviews emphasize organizational and ableist barriers as threats to retention for nurses who acquire disabilities [31]. More broadly, healthcare workforce turnover has also been associated with patient outcomes, reinforcing the relevance of retention-focused organizational policies in healthcare settings [32]. Taken together, these findings position disability inclusion in the healthcare workforce not only as a human resources concern but also as a health workforce equity issue with relevance to inclusive institutions and sustainable healthcare delivery.Taken together, these findings position disability inclusion in the healthcare workforce not only as a human resources concern but also as a health workforce equity issue with relevance to inclusive institutions and sustainable healthcare delivery.

Data were collected in 2023–2024, a period in which healthcare organizations were still adapting to post-COVID-19 workforce strain, retention challenges, and heightened

expectations for safety, fairness, and supportive management. Prior research during and after the pandemic indicates that perceived organizational support is closely linked to healthcare workers' well-being and work attitudes, and organizational trust has been highlighted as a key mechanism in sustaining functioning under uncertainty. Accordingly, examining support–trust–identification–commitment dynamics among disabled healthcare workers in the post-COVID period is conceptually relevant, because this group may face amplified structural barriers and psychosocial sensitivity to organizational cues.

This study aims to examine the relationships among perceived organizational support, organizational trust, organizational identification, and organizational commitment among disabled healthcare professionals working in public hospitals in Türkiye, while situating these relationships within a health workforce equity perspective.

While the proposed model is grounded in social exchange and social identity perspectives, disability scholarship suggests that employee–organization relationships may be shaped by mechanisms that are not fully captured in general workforce samples. From a structural (social) model of disability viewpoint, disadvantage stems primarily from organizational and environmental barriers (e.g., accessibility constraints, job design, and inadequate accommodations) rather than individual impairment. Accordingly, perceived organizational support among employees with disabilities can function as a salient signal of whether the organization meaningfully reduces structural barriers through accommodations and inclusive practices—thereby shaping trust, identification, and commitment.

In addition, stigma/ableism perspectives emphasize processes of labeling, stereotyping, anticipated discrimination, and status loss, which can heighten sensitivity to organizational cues. In such contexts, supportive actions and fair, inclusive practices may be especially important for building psychological safety and an inclusive climate, which in turn facilitate trust and identification. These complementary lenses motivate treating disability not merely as a demographic characteristic but as a context that can alter how support and trust translate into commitment, and they justify examining heterogeneity across disability characteristics where feasible. Therefore, we additionally explored whether key relationships vary by disability degree.

This study revisits the classic social exchange and social identity–based model linking perceived organizational support, organizational trust, organizational identification, and organizational commitment through the lens of disability. Because employees with disabilities are more likely to encounter structural and psychosocial workplace conditions (e.g., accommodation needs, accessibility constraints, and stigma/ableism), the mechanisms through which support and trust translate into identification and commitment may not fully mirror those observed in general employee samples. Disability is therefore positioned not merely as a demographic attribute but as a boundary condition shaping employee–organization exchange and identification processes.

Rather than introducing a new theory, the study explicitly tests the generalizability of this well-established model in a marginalized workforce segment—disabled healthcare workers in Turkish public hospitals—and, where feasible, explores whether key structural paths vary across disability characteristics (e.g., severity/type) via subgroup or multi-group comparisons.

The contribution of this study is not to propose a new theory, but to examine whether a classic support–trust–identification–commitment framework is observable within a

marginalized healthcare workforce and whether selected associations show heterogeneity by disability degree. Given the design constraints of the dataset, these aims should be understood as a theory-informed examination rather than definitive proof of a distinct disability-specific mechanism.

2 Materials and methods

2.1 Research design

This cross-sectional study was conducted in 15 public hospitals in Ankara between November 2023 and February 2024.

2.2 Research population and sample

The research population consisted of 1761 disabled healthcare workers employed in a total of 37 hospitals in Ankara, the capital of Türkiye. These hospitals included 11 training and research hospitals, 2 city hospitals, 23 state hospitals, and 1 occupational health hospital affiliated with the Ministry of Health. Applications for official research permits were made to the Ankara Provincial Health Directorate and all public hospitals; however, permits were only granted from 7 training and research hospitals and 8 state hospitals. No sampling method was used for the study; the aim was to reach 587 disabled healthcare workers in the hospitals that received permits, but responses were received from only 316 (53.8%) of them.

The study included all disabled healthcare professionals who: (i) had a report indicating a physical or mental disability, (ii) were actively working in authorized hospitals, and (iii) provided informed consent.

2.3 Instruments

The survey method was used as a data collection tool in the study. To determine the socio-demographic characteristics of the participants, a personal information form was used; to measure perceptions of organizational support, an 8-item scale developed by Eisenberger et al. [8], and revised by Shanock and Eisenberger [33], was used; to measure levels of organizational trust, a 12-item scale developed by Nyhan and Marlowe [34] was used; to measure levels of organizational identification, a 6-item scale developed by Mael and Ashforth [35] was used; and to measure organizational commitment, a 4-item scale used in the studies of Babin and Boles [36], Netemeyer et al. [37], and Hartline and Ferrell [38]was used. The Turkish adaptation of these four scales was done by Altaş [39].

All scales' response categories were based on a five-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree.

2.4 Data collection procedure

After the ethical approval process for the research was completed, hospital administrators were consulted and informed about the importance and scope of the study. The survey link was announced to disabled healthcare professionals by the management units of the relevant public hospitals. All participants voluntarily participated in the research and electronically confirmed their informed consent.

2.5 Statistical analysis

Research data were analyzed using SPSS (v29) and AMOS (v24). Descriptive statistics included frequencies and percentages, as well as means and standard deviations. The construct validity of the study measures was examined via confirmatory factor analysis (CFA), and the hypothesized relationships (direct, indirect, and total effects) were tested using structural equation modeling (SEM). Model adequacy was evaluated using standard goodness-of-fit indices. Internal consistency was assessed using Cronbach's alpha and omega total. Additional reliability diagnostics included mean inter-item correlations, corrected item-total correlations, and alpha-if-item-deleted statistics. Convergent validity was assessed using composite reliability (CR) and average variance extracted (AVE), and discriminant validity was examined using the Fornell–Larcker criterion and the heterotrait–monotrait ratio (HTMT).

In addition to SEM/path analysis, we tested whether disability degree moderated selected relationships using moderated multiple regression with interaction terms. Composite scores were computed as the mean of the respective items for perceived organizational support, organizational trust, organizational identification, and organizational commitment. Disability degree was dummy-coded into two indicators (Group 1 and Group 2), with Group 3 as the reference category. Predictors were mean-centered prior to creating interaction terms (e.g., Trust × Group 1, Trust × Group 2; Identification × Group 1, Identification × Group 2) to reduce multicollinearity. Main effects were entered first, followed by interaction terms; moderation was inferred from significant interaction coefficients and/or the change in explained variance (ΔR^2). Where appropriate, simple-slope estimates were calculated for each disability-degree group and the interaction patterns were visualized. Because subgroup sizes were uneven, the moderation findings were interpreted cautiously, particularly for the first-degree disability group.

Because all variables were collected via self-report questionnaires, potential common method bias (CMB) was assessed using both exploratory and confirmatory approaches. First, Harman's single-factor test was conducted by entering all 30 measurement items into an unrotated exploratory factor analysis to examine the proportion of variance explained by the first factor. Second, we estimated a single-factor CFA model (all items loading on one latent factor) and compared its fit with a common latent factor (CLF) specification added to the theorized measurement structure as a robustness check, examining whether substantive parameter estimates materially changed. To address potential institutional (hospital-type) bias given the predominance of teaching and research hospitals in the sample, hospital type was additionally included as a control variable in a sensitivity analysis predicting organizational commitment.

Given the very high Cronbach's alpha values observed for some scales, reliability findings—particularly for organizational trust—were interpreted cautiously as evidence of strong item homogeneity that may also reflect item overlap.

3 Results

3.1 Scale validity and reliability

In this study, the construct validity of the organizational support, organizational trust, organizational identification, and organizational commitment measures was examined using confirmatory factor analysis (CFA). The four-factor measurement model

demonstrated acceptable model fit (χ^2/df = 2.41; CFI = 0.95; GFI = 0.92; AGFI = 0.90; TLI = 0.94; RMSEA = 0.06; SRMR = 0.04), supporting the theorized factor structure (Table 1).

Standardized factor loadings were substantial (range = 0.67–0.97) (Table 2).

Internal consistency, convergent validity, and discriminant validity were further examined using additional psychometric indicators. Cronbach's alpha and omega total values ranged from 0.939 to 0.981, indicating high internal consistency across the four constructs. Mean inter-item correlations ranged from 0.677 to 0.835, corrected item-total correlations ranged from 0.656 to 0.945, and alpha-if-item-deleted values remained high across all scales. These findings supported the internal consistency of the measures; however, the very high reliability coefficients, particularly for organizational trust, were interpreted cautiously because they may also indicate item overlap.

Convergent validity was supported by composite reliability and average variance extracted values. Composite reliability values ranged from 0.939 to 0.981, and AVE values ranged from 0.685 to 0.836, exceeding commonly used threshold values. Discriminant validity was also supported. The square roots of AVE ranged from 0.828 to 0.914 and were higher than the corresponding inter-construct correlations. In addition, HTMT values ranged from 0.694 to 0.834, remaining below the conservative 0.85 threshold. Overall, these findings supported the measurement adequacy and construct distinctiveness of the four-factor structure.

Common method bias (CMB). Given that all variables were collected via self-report, we assessed potential CMB using complementary approaches. Harman's single-factor test (unrotated) showed that the first factor accounted for 66.27% of the total variance across the 30 items. To complement this exploratory check, a single-factor CFA model (all items loading on one latent factor) showed poor fit (χ^2/df = 10.29; CFI = 0.717; TLI = 0.696; RMSEA = 0.172), indicating that a single common factor does not adequately reproduce the observed covariance among items. As an additional robustness check, a latent common factor specification (i.e., allowing an additional general factor to capture shared item covariance) improved fit (χ^2/df = 3.52; CFI = 0.944; TLI = 0.918; RMSEA = 0.089). Taken together, these results indicate substantial shared method variance; accordingly, the observed associations should be interpreted cautiously because same-source measurement may have inflated some relationships.

Sensitivity analysis (hospital type). Because the sample was predominantly drawn from teaching and research hospitals (90.8%), we additionally controlled for hospital type in predicting organizational commitment (with perceived organizational support, organizational trust, and organizational identification included as predictors). Hospital type was not a significant covariate (β = –0.044, p = .660) and its inclusion did not materially

Table 1 Model fit indices and evaluation

Fit index	Model value	Acceptable thresholds*	Interpretation
χ^2/df	2.41	< 3.00	Good fit
CFI	0.96	≥ 0.90 (good), ≥ 0.95 (excellent)	Excellent fit
TLI	0.95	≥ 0.90 (good), ≥ 0.95 (excellent)	Good fit
RMSEA	0.06	< 0.08 (good), < 0.06 (excellent)	Good fit
SRMR	0.04	< 0.08	Excellent fit
GFI	0.92	≥ 0.90	Good fit
AGFI	0.90	≥ 0.85	Good fit

Acceptable limits are specified based on the compliance criteria of Hu & Bentler [40], Kline [41], and Hair et al. [42]

Table 2 Confirmatory factor analysis (CFA) and reliability findings of research scales

Item	β	%95 CI		*p*	Cronbach's α
		Lower	Upper		
Perceived Organizational Support Scale					0.941
POS1	0.869	0.820	0.909	< 0.001	
POS2	0.920	0.892	0.944	< 0.001	
POS3	0.935	0.911	0.955	< 0.001	
POS4	0.872	0.816	0.913	< 0.001	
POS5	0.793	0.731	0.844	< 0.001	
POS6	0.865	0.817	0.904	< 0.001	
POS7	0.668	0.558	0.756	< 0.001	
POS8	0.667	0.547	0.766	< 0.001	
Organizational Commitment Scale					0.952
OC1	0.887	0.816	0.935	< 0.001	
OC2	0.963	0.940	0.982	< 0.001	
OC3	0.907	0.834	0.957	< 0.001	
OC4	0.900	0.845	0.942	< 0.001	
Organizational Identification Scale					0.939
OI1	0.766	0.633	0.872	< 0.001	
OI2	0.772	0.657	0.860	< 0.001	
OI3	0.893	0.846	0.931	< 0.001	
OI4	0.926	0.889	0.955	< 0.001	
OI5	0.888	0.799	0.948	< 0.001	
OI6	0.847	0.748	0.922	< 0.001	
Organizational Trust Scale					0.981
Trust in Supervisor Subscale					0.982
OT1	0.910	0.857	0.948	< 0.001	
OT2	0.949	0.923	0.968	< 0.001	
OT3	0.858	0.760	0.934	< 0.001	
OT4	0.947	0.919	0.967	< 0.001	
OT5	0.942	0.914	0.964	< 0.001	
OT6	0.965	0.946	0.981	< 0.001	
OT7	0.958	0.932	0.978	< 0.001	
OT8	0.942	0.907	0.966	< 0.001	
Trust in the Organization Subscale					0.951
OT9	0.952	0.914	0.984	< 0.001	
OT10	0.964	0.943	0.983	< 0.001	
OT11	0.818	0.722	0.893	< 0.001	
OT12	0.896	0.846	0.936	< 0.001	

change model explanatory power ($\Delta R^2 \approx 0.00016$), suggesting that the main conclusions are robust to institutional composition.

3.2 Participant characteristics

A total of 316 disabled healthcare workers participated in the study; their average age was 43.5 ± 8.0, 50.9% were female, 75.6% were married, and 57.6% were university graduates. 59.8% had disabilities due to illness, 66.1% had a Grade 3 disability (40%-59%), and 42.7% had orthopedic-physical disabilities. 90.8% worked in training and research hospitals. The average length of service was 18.5 ± 8.6 years (Table 3).

Table 3 Sociodemographic and occupational characteristics of participants ($n = 316$)

Characteristic	Category	*n*	%
Age (years)	43.5 ± 8.0 (Mean ± SD)		
Gender	Male	155	49.1
	Female	161	50.9
Marital status	Single	77	24.4
	Married	239	75.6
Educational level	Lower secondary school of below	13	4.1
	High school	78	24.7
	University (Bachelor's)	182	57.6
	Postgraduate	43	13.6
Disability severity	First-degree disability (80–99%)	41	13.0
	Second-degree disability (60–79%)	66	20.9
	Third-degree disaility (40–59%)	209	66.1
Type of disability	Orthopedic/physical	135	42.7
	Visual impairment	31	9.8
	Hearing impairment	33	10.4
	Intellectual disability	12	3.8
	Chronic illness	102	32.3
	Other	3	0.9
Hospital type	Training and research hospital	287	90.8
	State hospital	29	9.2
Total years of work experience (years)	18.5 ± 8.6 (Mean ± SD)		
Years in current institution (years)	11.6 ± 7.7 (Mean ± SD)		
Job title/position	Physician	26	8.2
	Midwife/Nurse	59	18.7
	Technician/Technologist (e.g., health officer, technician/technologist, laboratory technician, medical secretary, radiology technician, dental technician)	65	20.6
	Other allied health professionals (e.g., biologist, physicist/engineer, dietitian, physiotherapist, patient care staff, psychologist, support staff, orderly, engineer)	59	18.7
	General administrative services (e.g., clerical officer, civil servant, secretary, data entry)	70	22.2
	Other (e.g., worker, switchboard operator, cleaning staff)	37	11.7
Are you working in the position to which you were appointed?	Yes	288	91.1
	No	28	8.9
Overall, are you satisfied with working in this workplace?	Yes	281	88.9
	No	35	11.1
Do you use assistive devices/equipment related to your disability for your job?	Yes	25	7.9
	No	291	92.1
Does your institution provide the required assistive devices/equipment? ($n = 25$)	Yes	13	52.0
	No	12	48.0
In your opinion, is there a need for physical modifications in your workplace to accommodate your disability?	Yes	52	16.5
	No	264	83.5

Table 3 (continued)

Characteristic	Category	*n*	%
Are you satisfied with your salary?	Yes	198	62.7
	No	118	37.3
Do you need caregiver support during working hours (e.g., eating/drinking, personal care, mobility assistance)?	Yes	15	4.7
	No	301	95.3

Table 4 Organizational attitudes of disabled healthcare workers

Variable	Number of items	Cronbach's α	Min	Max	Mean (M)	SD
Perceived Organizational Support	8	0.94	1.00	5.00	3.48	0.85
Organizational Trust	12	0.98	1.00	5.00	3.67	0.86
Organizational Identification	6	0.94	1.00	5.00	3.76	0.77
Organizational Commitment	4	0.95	1.00	5.00	3.67	0.90

3.3 Findings regarding participants' levels of organizational support, organizational trust, organizational identification, and organizational commitment

The findings regarding the levels of organizational support, organizational trust, organizational identification, and organizational commitment of disabled healthcare workers are presented in Table 4. The average perception of organizational support among disabled healthcare workers was 3.48, the average levels of organizational trust and commitment were 3.67, and the average level of organizational identification was 3.76.

Construct-level correlations among the core study variables were all positive and statistically significant (Spearman r values: perceived organizational support–organizational commitment = 0.692, perceived organizational support–organizational identification = 0.580, perceived organizational support–organizational trust = 0.717, organizational commitment–organizational identification = 0.760, organizational commitment–organizational trust = 0.750, and organizational identification–organizational trust = 0.665; all $p < .001$). These coefficients indicate substantial relatedness among the variables and further support cautious interpretation in light of same-source measurement.

3.4 Structural equation modeling findings

In this study, SEM analysis was conducted to examine the direct and indirect associations among perceived organizational support, organizational trust, organizational identification, and organizational commitment. The model's fit indices ($\chi^2/df = 2.41$; CFI = 0.95; GFI = 0.92; AGFI = 0.90; TLI = 0.94; RMSEA = 0.06; SRMR = 0.04) were within acceptable ranges, and the factor loadings of the scales ranged from 0.67 to 0.97. Red arrows in the model indicate statistically significant paths (Fig. 1).

According to the findings in Fig. 1, among disabled healthcare workers, organizational support explains 65.3% of the variance in organizational trust, perceived organizational support and organizational trust explain 69% of the variance in organizational identification, and perceived organizational support, organizational trust, and organizational identification explain 80.2% of the variance in organizational commitment.

The analysis findings regarding the direct, indirect, and total effects between the research scales are presented in Table 5.

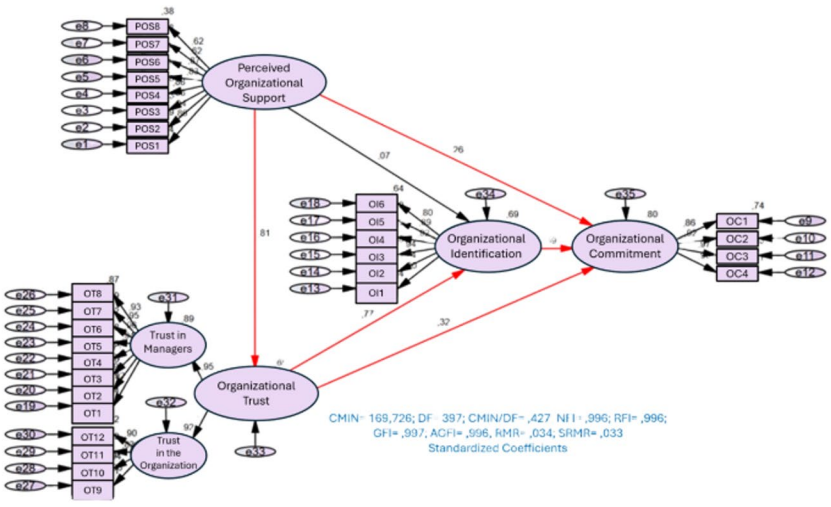


Fig. 1 Structural equation model

Table 5 Structural equation model analysis findings

Path	B *	B **	SE ***	95% CI for β		*p*
				Lower	Upper	
Direct Effects						
Organizational Support → Organizational Trust	0.858	0.808	0.082	0.693	0.904	< 0.001
Organizational Support → Organizational Identification	0.056	0.069	0.138	-0.309	0.344	0.725
Organizational Support → Organizational Commitment	0.229	0.258	0.103	0.058	0.495	0.012
Organizational Trust → Organizational Identification	0.597	0.774	0.146	0.499	1.140	< 0.001
Organizational Trust → Organizational Commitment	0.269	0.322	0.132	0.055	0.659	0.016
Organizational Identification → Organizational Commitment	0.421	0.389	0.122	0.154	0.569	0.002
Indirect Effects						
Organizational Support → Organizational Identification	0.512	0.626	0.163	0.375	1.012	< 0.001
Organizational Support → Organizational Commitment	0.470	0.530	0.087	0.350	0.699	< 0.001
Organizational Trust → Organizational Commitment	0.251	0.301	0.092	0.135	0.492	0.002
Total Effects						
Organizational Support → Organizational Trust	0.858	0.808	0.055	0.693	0.904	< 0.001
Organizational Support → Organizational Identification	0.568	0.694	0.049	0.593	0.784	< 0.001
Organizational Support → Organizational Commitment	0.698	0.788	0.048	0.685	0.873	< 0.001
Organizational Trust → Organizational Identification	0.597	0.774	0.164	0.499	1.140	< 0.001
Organizational Trust → Organizational Commitment	0.520	0.623	0.141	0.334	0.882	< 0.001
Organizational Identification → Organizational Commitment	0.421	0.389	0.105	0.154	0.569	0.002

* Unstandardized regression coefficient (B)

** Standardized regression coefficient (β)

*** Standard error (SE)

As shown in Table 5, perceived organizational support was positively associated with organizational trust and organizational commitment, organizational trust was positively associated with organizational identification and organizational commitment, and organizational identification was positively associated with organizational commitment. The direct path from perceived organizational support to organizational identification was not statistically significant. Indirect associations were observed from perceived organizational support to organizational identification and organizational commitment via trust, and from organizational trust to organizational commitment via organizational

identification. Overall, the largest standardized coefficient was observed for the association between perceived organizational support and organizational trust.

3.5 Moderation analysis: disability degree as a moderator

Moderation analysis was conducted using interaction terms for disability degree (Group 1 = first-degree disability [80–99%; $n = 41$], Group 2 = second-degree disability [60–79%; $n = 66$], and Group 3 = third-degree disability [40–59%; $n = 209$; reference]). The interaction block contributed a small increase in explained variance ($\Delta R^2 = 0.005$). The moderation model coefficients are presented in Table 6, and the interaction patterns are illustrated in Fig. 2A and B.

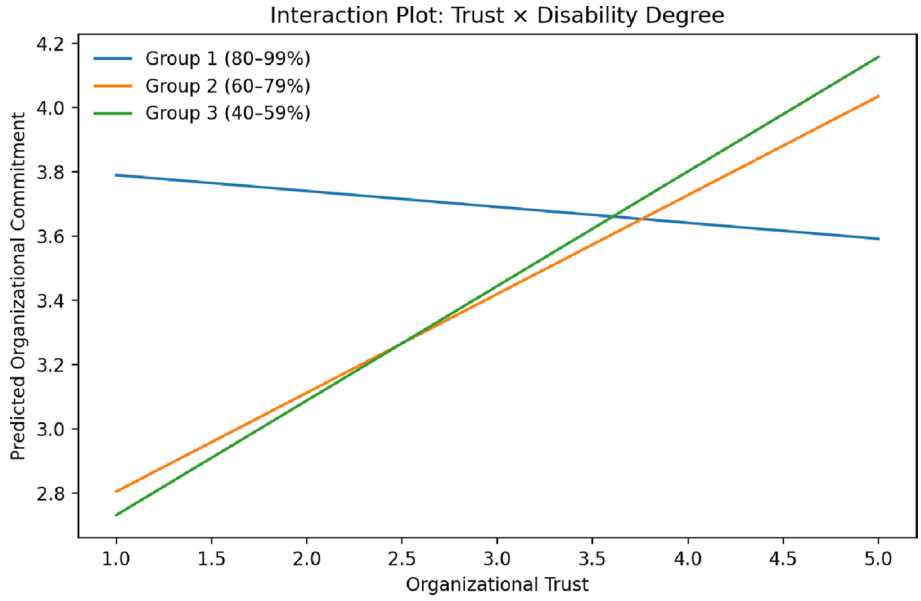
In the support-adjusted model, the Trust × Group 1 interaction was statistically significant (b = – 0.406, $p = .029$), indicating that the association between organizational trust and organizational commitment was weaker among participants with first-degree disability than among those with third-degree disability, the reference group. The Trust × Group 2 interaction was not statistically significant (b = – 0.049, $p = .767$), suggesting that the trust–commitment association in Group 2 did not differ significantly from the reference group.

Simple-slope estimates were reported narratively to reduce table density. Organizational trust was positively associated with organizational commitment in Group 3 (b = 0.357, SE = 0.059, $p < .001$), whereas this association was not significant in Group 1 (b = – 0.050, SE = 0.180, $p = .783$). In Group 2, the association was positive but borderline non-significant (b = 0.308, SE = 0.163, $p = .059$). These findings indicate that the positive trust–commitment relationship was most evident in the third-degree disability group and was attenuated in the first-degree disability group.

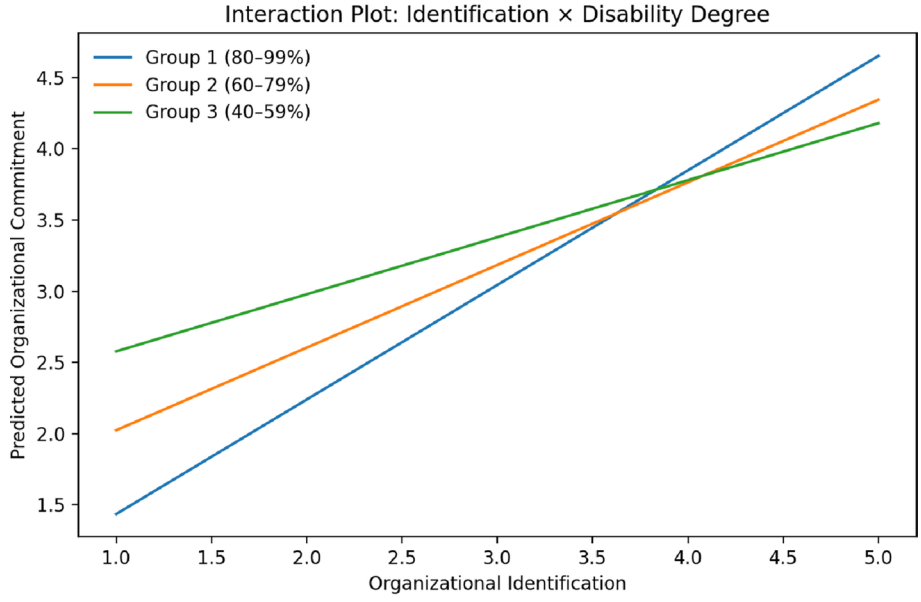
For organizational identification, the Identification × Group 1 interaction approached statistical significance (b = 0.404, $p = .059$), while the Identification × Group 2 interaction was not significant (b = 0.180, $p = .333$). Simple-slope estimates showed that organizational identification was positively associated with organizational commitment in all disability-degree groups, with the strongest slope observed in Group 1 (b = 0.804, SE = 0.206, $p < .001$), followed by Group 2 (b = 0.580, SE = 0.176, $p = .001$) and Group 3 (b = 0.401, SE = 0.058, $p < .001$). This pattern suggests that organizational identification may be particularly important for commitment among employees with first-degree disability. However, because subgroup sizes were uneven, especially for Group 1, these moderation findings should be interpreted cautiously.

Table 6 Moderation model coefficients predicting organizational commitmentt

Term	b	SE	t	*p*	95% CI
Intercept	3.685	0.032	116.335	< 0.001	3.622 to 3.747
support_c	0.283	0.048	5.929	< 0.001	0.189 to 0.376
trust_c	0.357	0.059	6.079	< 0.001	0.241 to 0.472
identification_c	0.401	0.058	6.861	< 0.001	0.286 to 0.516
g1	− 0.027	0.078	− 0.342	0.732	− 0.181 to 0.127
g2	− 0.058	0.065	− 0.879	0.380	− 0.186 to 0.071
trust_c: g1	− 0.406	0.185	− 2.195	0.029	− 0.770 to − 0.042
trust_c: g2	− 0.049	0.165	− 0.297	0.767	− 0.373 to 0.275
identification_c: g1	0.404	0.213	1.892	0.059	− 0.016 to 0.824
identification_c: g2	0.180	0.185	0.969	0.333	− 0.185 to 0.544



A



B

Fig. 2 **A** Trust × disability degree interaction plot **B** Identification × disability degree interaction plot

4 Discussion

This study examined the relationships among perceived organizational support, organizational trust, organizational identification, and organizational commitment among disabled healthcare workers employed in public hospitals in Türkiye. Higher perceived organizational support was associated with higher organizational trust and commitment, and higher organizational trust was associated with higher organizational identification

and commitment. These findings are relevant from a health workforce equity perspective because disability inclusion in healthcare organizations is closely connected to fair working conditions, inclusive institutions, and sustainable workforce participation.

The post-COVID-19 context may have amplified the importance of organizational support and trust. During this period, transparent communication, safety climate, equitable resource allocation, and consistent accommodations remained particularly salient for healthcare workers. For disabled employees, such organizational cues may carry additional meaning because day-to-day work participation can depend on accessibility, accommodation, and inclusion practices.

The strongest association in the model was between perceived organizational support and organizational trust. This is compatible with social exchange interpretations in which supportive treatment is read as a signal that the organization values the employee. This finding is also consistent with recent evidence suggesting that organizational trust may help explain the link between perceived organizational support and affective organizational commitment [45]. However, because the design was cross-sectional and self-reported, the direction and ordering of these associations cannot be confirmed.A notable result was the absence of a statistically significant direct association between perceived organizational support and organizational identification, alongside a significant indirect association via trust. This pattern is consistent with—but does not prove—the possibility that support becomes identification-relevant when it is interpreted as reliable and fair enough to foster trust. However, this interpretation should remain cautious. Although discriminant validity was supported by both the Fornell–Larcker criterion and HTMT, same-source measurement remained substantial and several construct correlations were still high.

Interpreting the findings through structural disability and stigma or ableism lenses remains useful. When employees anticipate bias or face day-to-day accessibility and accommodation barriers, organizational cues may be especially meaningful. Within such a context, support and trust may plausibly matter for belonging and commitment, even though the present dataset cannot establish these processes causally.

The finding that organizational trust was positively associated with both organizational identification and organizational commitment is also consistent with prior literature. In high-responsibility and team-based environments such as healthcare, trust may be relevant to how employees interpret their relationship with the organization and whether they feel psychologically attached to it. In this sense, the present results are compatible with previous work showing that trust, identification, and commitment are closely related employee attitudes [46, 47].

The moderation results further suggest that disability degree may shape how trust and identification relate to commitment. The significant Trust × Group 1 interaction indicated that the positive association between organizational trust and commitment was weaker among participants with first-degree disability than among those with third-degree disability. In contrast, the identification–commitment association was strongest in the first-degree disability group. This pattern may indicate that, for employees with a higher disability degree, organizational commitment is less strongly anchored in generalized trust and more strongly linked to whether they feel psychologically included, represented, and identified with the organization. From a disability inclusion perspective, this is plausible because employees with higher disability severity may be more dependent on

concrete organizational practices such as accessibility, accommodation, respectful communication, and role fit. Nevertheless, these moderation findings should be interpreted cautiously because the first-degree disability subgroup was relatively small.

The practical implications should therefore be understood as reasonable organizational considerations rather than effects directly demonstrated by this dataset. Public hospitals may benefit from reviewing accommodation processes, accessibility-aware job design, fair supervisory practices, and respectful communication norms as part of broader disability-inclusive workforce policy.

4.1 Limitations and future research

There are several limitations to consider when evaluating these findings. First, the cross-sectional design precludes causal inference or temporal ordering. The SEM results indicate statistical associations and indirect patterns, not verified mediation. Although data were collected in the post-COVID-19 period, we did not directly measure COVID-related exposure, unit-level crisis intensity, or pandemic-specific organizational practices; future studies should model these contextual factors explicitly.

Second, the study was limited to disabled healthcare workers employed in public hospitals in Ankara. Because 90.8% of participants were drawn from training and research hospitals, the findings should not be generalized uncritically to other public hospital settings, private institutions, or non-Turkish contexts. In addition, because no non-disabled comparison group was included, the study cannot directly test whether the model operates differently for disabled versus non-disabled healthcare workers.

Third, all core variables were measured by self-report at a single time point. The Harman result (66.27% variance in the first factor) and the improved fit of the common latent factor specification indicate that common method variance is a serious design constraint that may have inflated some associations. The moderation findings also require caution because they relied on interaction regressions using composite scores and included a relatively small first-degree disability subgroup.

Finally, although the four-factor CFA, Fornell–Larcker criterion, and HTMT results supported the theorized measurement structure and construct distinctiveness, several inter-construct correlations remained high, and the study did not directly measure inclusive climate, psychological safety, perceived stigma or ableism, or accommodation adequacy. Future research should address these psychometric and contextual issues using more comprehensive measurement strategies and multi-source or longitudinal designs.

5 Conclusion

This study examined the associations among perceived organizational support, organizational trust, organizational identification, and organizational commitment in disabled healthcare professionals working in public hospitals in Türkiye. The findings indicate that perceived organizational support was positively associated with organizational trust and commitment, and that organizational trust was positively associated with organizational identification and commitment. In the present sample, the direct association between perceived organizational support and organizational identification was not statistically significant, whereas the indirect association via trust was significant. These

results are consistent with a trust-linked pattern, but they should be interpreted cautiously because of the cross-sectional self-report design and substantial shared method variance.

For practice, the findings support attention to disability-inclusive workforce policies in public hospitals. Formal accommodation processes, accessibility-aware supervision, fair communication, and psychologically respectful workplace routines may be reasonable organizational priorities. These implications should be read as policy-oriented considerations derived from the observed pattern of associations, not as intervention effects directly demonstrated by the present dataset.

From a public health systems perspective, strengthening the inclusion of disabled healthcare workers may contribute to a fairer and more sustainable health workforce. Further research using institutionally diverse samples, comparison groups, multi-source data, and stronger psychometric reporting is needed before firmer conclusions are drawn.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12982-026-02245-x.

Supplementary Material 1

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Author contributions
MK was the principal investigator and was responsible for the study concept, design, data collection, and overall project supervision. ÜT contributed to the research design, supported the data analysis process, and assisted in the interpretation of results. IS and BS was responsible for drafting the manuscript, editing the text, and implementing revisions based on critical feedback. All authors read and approved the final version of the manuscript.

Data availability
This study is derived from a master's thesis completed in the Department of Health Management at Lokman Hekim University Institute of Health Sciences. The author confirms that all data generated or analyzed in that thesis are included in this published article. Furthermore, primary and secondary sources and data supporting the findings of this study were publicly available at the time the article was submitted.

Declarations

Ethics approval and consent to participate
This study was conducted in accordance with the Declaration of Helsinki and received ethical approval form the Lokman Hekim University Scientific Research Ethics Committee (Approval No: 2023/9; 20 September 2023). All participants provided informed consent prior to participation in the research.

Consent for publication
Yes.

Competing interests
The authors declare no competing interests.

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