



Quiet Quitting in Healthcare: A Conceptual Examination of Disengagement in High-Demand Professions

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Abstract

Quiet quitting—intentional minimum-effort compliance without formal resignation—has been increasingly documented across occupational settings, yet its specific manifestation among healthcare professionals in high-demand, resource-constrained work environments remains conceptually underdeveloped. This paper addresses that gap by developing an integrative conceptual account of quiet quitting as a structurally induced disengagement pattern in healthcare professions, distinct from burnout, turnover intention, and organizational cynicism. Drawing on literature spanning the definitional architecture of quiet quitting, Job Demands–Resources theory, healthcare-specific structural antecedents such as understaffing and moral distress, and documented consequences of workforce disengagement for organizational performance and care delivery, the paper argues that quiet quitting is better understood as a deliberate, bounded calibration response to sustained imbalance between occupational demands and organizational resources than as an individual motivational deficit. From this synthesis, the paper develops a four-stage Demand–Resource Calibration Pathway—structural exposure, appraisal and calibration, behavioral manifestation, and organizational consequence—and advances three conceptual propositions concerning the chronicity of demand–resource imbalance, the agency-contingent divergence between calibration-based and exhaustion-based disengagement, and the earlier-signal function of quiet quitting relative to conventional turnover and burnout metrics. The framework carries implications for healthcare organizational practice, suggesting that discretionary-effort indicators may offer earlier and more actionable evidence of workforce strain than exit or exhaustion-based measures alone, and that structural remediation of staffing and workload conditions is likely to be more effective than individual-focused engagement interventions in isolation. The propositions advanced remain conceptual and are offered as a basis for future empirical validation rather than as confirmed findings.

Keywords: *quiet quitting; healthcare workforce disengagement; job demands–resources theory; moral distress; healthcare organizational performance; workforce sustainability*

1. Introduction

Healthcare systems worldwide continue to confront a persistent workforce paradox: even as institutional attention to burnout, turnover, and staff wellbeing has intensified, a subtler and less visible pattern of disengagement has emerged among professionals who remain formally employed but withdraw discretionary effort, initiative, and psychological investment from their roles. This pattern, popularly labeled “quiet quitting,” describes employees who continue to perform the minimum requirements of their positions while disengaging from the extra-role behaviors—flexibility, advocacy, mentorship, continuous improvement—that healthcare delivery has historically depended upon informally. Unlike resignation, absenteeism, or overt burnout, quiet quitting leaves organizational staffing numbers intact while eroding the discretionary labor that sustains care quality, team cohesion, and organizational adaptability. In high-demand healthcare professions characterized by chronic understaffing, emotional labor, and sustained exposure to moral and physical strain, this form of withdrawal carries consequences that extend beyond individual job satisfaction into the operational and strategic capacity of healthcare organizations themselves.

The scholarly treatment of this phenomenon, however, remains underdeveloped and conceptually imprecise. Much of the existing discourse on quiet quitting originates from general workforce and organizational-behavior commentary rather than from healthcare-specific inquiry, and it frequently conflates the construct with adjacent but distinct phenomena such as burnout, organizational cynicism, and turnover intention. Burnout research has produced a mature body of theory describing exhaustion, depersonalization, and reduced personal accomplishment as outcomes

of chronic occupational stress, while turnover-intention research addresses the cognitive and behavioral precursors to voluntary exit. Quiet quitting, by contrast, describes a durable equilibrium state in which the employee neither exits nor recovers engagement, but settles into a bounded, minimal-effort mode of continued employment. This equilibrium state has not been adequately theorized within healthcare-specific literature, despite its plausible connection to some of the most consequential problems facing contemporary health systems: workforce sustainability, staffing adequacy, care continuity, and organizational performance under conditions of chronic resource strain.

The healthcare sector presents a particularly consequential setting in which to examine this phenomenon. Healthcare professionals operate within occupational structures marked by high emotional and physical demand, rigid staffing ratios, regulatory and safety obligations, and limited slack capacity to absorb disengagement without operational consequence. Where quiet quitting in a conventional corporate environment may manifest as reduced innovation or diminished collaborative initiative, its analogue in healthcare settings may manifest as reduced vigilance, diminished willingness to cover gaps in coverage, withdrawal from quality-improvement participation, or attenuated interpersonal engagement with patients and colleagues—outcomes with direct bearing on organizational performance and the operational reliability of care delivery. Understanding quiet quitting as a distinct organizational phenomenon within healthcare work environments is therefore not merely a matter of terminological precision; it has material implications for how healthcare organizations diagnose workforce risk, design retention and engagement strategies, and interpret the gap between adequate staffing levels and adequate functional capacity.

At present, the conceptual vocabulary available to healthcare management scholarship does not clearly separate quiet quitting from its neighboring constructs, nor does it offer a coherent account of the organizational and structural conditions that produce it within high-demand healthcare professions specifically. This creates an unresolved intellectual problem: without a clear conceptual architecture distinguishing quiet quitting from burnout and turnover intention, and without an account of its structural antecedents and organizational consequences, healthcare management scholarship and practice risk treating a structurally induced disengagement pattern as an individual motivational failing—an interpretive error with direct consequences for how healthcare organizations design interventions.

This paper addresses that problem by developing a conceptual account of quiet quitting as an organizational and health-system phenomenon rather than an individual attitudinal deficit. In doing so, it differentiates quiet quitting from burnout, disengagement, and turnover intention as they have been theorized in healthcare-specific contexts; examines the structural and organizational antecedents that give rise to disengagement in high-demand healthcare professions; and develops a conceptual framework linking this disengagement pattern to healthcare organizational performance and health-system delivery capacity. From this framework, the paper derives implications relevant to healthcare management practice, particularly with respect to how healthcare organizations might identify, interpret, and respond to disengagement before it manifests as either overt burnout or workforce attrition.

The argument proceeds on the premise that quiet quitting in healthcare settings is best understood as a structurally induced response to sustained imbalances between the demands placed upon healthcare professionals and the organizational resources available to meet them, rather than as an isolated individual choice. This reframing carries consequences for healthcare organizational analysis: it shifts the locus of explanation from individual disposition toward organizational design, workload architecture, and resource allocation, and it positions disengagement as a leading indicator of organizational and health-system strain rather than merely a downstream symptom of individual burnout. The sections that follow develop this argument through a synthesis of relevant literature, a conceptual analysis of the mechanisms linking healthcare work conditions to disengagement, and a discussion of the implications this reframing holds for healthcare organizational performance and management practice.

2. Review of Related Literature

2.1 Conceptualizing Quiet Quitting: Origins, Definitions, and Distinctions from Related Constructs

Across the literature, quiet quitting is converging toward a definition centered on intentional minimum compliance: employees remain formally employed, continue to meet the explicit requirements of their roles, and deliberately withhold effort beyond what is contractually specified (Gray et al., 2025; Harris, 2024; Atiq et al., 2026; Cesaro & Daicampi, 2026). Concept analyses and scoping reviews converge on a recurring set of definitional elements—minimal effort, continued organizational membership, nonresignation, and a degree of psychological

detachment or boundary-setting (Bernuzzi et al., 2025; Jalali et al., 2026; Yasin et al., 2025; Maheshwari, 2026). Several authors note that while the label itself is recent, the underlying behavior overlaps with older traditions of workplace withdrawal and disengagement, occupying a narrower behavioral space centered specifically on effort restriction rather than exit or affective collapse (Atiq et al., 2026; Bernuzzi et al., 2025; Harris, 2024; Soutzidou et al., 2026). Importantly, the behavior is typically framed as deliberate rather than incidental or purely affective (Gray et al., 2025; Joe & Dhanpat, 2026), and frequently includes active boundary-setting against overwork rather than a simple absence of motivation (Jalali et al., 2026; Maheshwari, 2026; Aydın & Levent, 2025). At the same time, several scholars caution that the construct remains only partially settled, with ongoing ambiguity in how tightly its boundaries are drawn (Dilchert et al., 2025; Sugaguil et al., 2026; Karrani et al., 2023).

The literature is comparatively consistent in distinguishing quiet quitting from burnout, even though the two constructs are closely related and frequently co-occur (Yasin et al., 2025; Geng et al., 2025; Cesaro & Daicampi, 2026). Burnout is characterized as an exhaustion-based depletion state with clear health implications, whereas quiet quitting is characterized as a more deliberate behavioral calibration of effort that remains within—rather than outside—the formal boundaries of the role (Yasin et al., 2025; Joe & Dhanpat, 2026; Soutzidou et al., 2026; Patel et al., 2025). A parallel distinction separates quiet quitting from turnover intention, which concerns plans to exit the organization, whereas quiet quitting concerns remaining while minimizing investment (Yasin et al., 2025; Gray et al., 2025). Organizational cynicism is similarly treated as a distinct construct rooted in psychological distancing and loss of meaning, whereas quiet quitting centers more narrowly on behavioral minimum contribution and, notably, can occur in the absence of either cynicism or emotional exhaustion (Patel et al., 2025). Several sources treat burnout as an antecedent or correlate of quiet quitting rather than an equivalent construct (Jalali et al., 2026; Yasin et al., 2025; Bernuzzi et al., 2025), and caution that definitions of quiet quitting become conceptually weak when burnout or turnover intention are folded directly into the definition itself (Gray et al., 2025). A minority position adds further nuance, observing that boundary-setting around contractual duties does not automatically indicate disengagement, since limiting effort and withdrawing commitment are not identical phenomena (Cesaro & Daicampi, 2026). Evidence from a Philippine higher education workplace similarly shows that work meaning varies across employment conditions, reinforcing the need to distinguish motivational states from specific withdrawal behaviors (Aguilar, 2026).

The construct's most consistently observed behavioral signature is a reduction in discretionary effort and extra-role behavior (Yasin et al., 2025; Atiq et al., 2026; Maheshwari, 2026), manifesting as reduced volunteering, declined informal leadership, and diminished initiative beyond formally assigned duties (Yasin et al., 2025; Bernuzzi et al., 2025; Öztürk et al., 2023). This pattern extends to reduced organizational citizenship behavior, although a live conceptual debate persists over whether such citizenship withdrawal should be treated as a defining feature of quiet quitting or as a downstream consequence of it (Gray et al., 2025; Sugaguil et al., 2026). Taken together, the literature positions quiet quitting as a distinct, deliberate, resource-protective behavioral pattern—related to, but not reducible to, burnout, cynicism, or turnover intention—a distinction that carries direct significance for how the phenomenon should be interpreted within high-demand healthcare professions rather than folded into existing exhaustion- or exit-based frameworks. In frontline retail, engagement was strongly associated with autonomy, growth opportunities, and teamwork under agile leadership, suggesting discretionary contribution is sensitive to work-design and relational resources (Gonzales & Magnaye, 2026).

2.2 Job Demands, Resources, and Psychological Disengagement in High-Demand Professions

Job Demands–Resources (JD-R) theory provides the dominant explanatory architecture linking occupational conditions to disengagement, framing employee well-being as the joint product of two counteracting processes: demands that fuel strain, and resources that fuel motivation and engagement (Bakker et al., 2022; Bakker & Demerouti, 2024). Within this framework, disengagement is understood to emerge specifically when demands are high and resources are insufficient to offset them, with risk compounding when both conditions occur simultaneously (Gynning et al., 2024; Saraiva & Nogueiro, 2025; Li et al., 2025). Empirical work in nursing populations supports this pattern directly: the combination of high demands and low resources predicted both low engagement and high exhaustion (Portoghese et al., 2025), while limited resources elevated disengagement risk even when demands were only moderate (Gynning et al., 2024). Related evidence extends this dynamic to boundary-spanning demands such as after-hours connectivity, which combined with low organizational support to increase psychological contract violation and distress (Li et al., 2025). Cross-sector evidence from Philippine trading firms likewise identified work-environment support as the strongest predictor of productivity, consistent with treating supportive conditions as performance-enabling resources (Espelita & Atento, 2026).

The association between high job demands and reduced engagement appears especially consistent within high-stress, care-intensive occupations, including nursing and emergency care (Huhtala et al., 2021; Thapa et al., 2022; Myrberg et al., 2026). Intensified demands in healthcare settings have been linked to either heightened exhaustion or reduced engagement, with no positive well-being pathway identified (Huhtala et al., 2021), and quantitative demands, emotional demands, and work pace have each shown negative associations with thriving among nursing staff (Myrberg et al., 2026). The literature does, however, identify an important qualification to this pattern: high demands do not invariably suppress engagement, and may coexist with sustained engagement when resources are strong and emotional overload remains controlled—though this configuration appears to represent the exception rather than the general rule (Thapa et al., 2022; Ni et al., 2024). This nuance matters for a conceptual account of quiet quitting in healthcare, since it suggests that the demand–resource imbalance, rather than demand level alone, is the more precise mechanism driving disengagement. A comparable pattern appears in demanding marine work, where occupational context shaped employee time attitudes more strongly than basic demographics (Wang, 2026). Among dormitory medical students, sleep and physical activity were also associated with exhaustion and depersonalization markers, illustrating resource-strain dynamics in a high-demand medical setting (Quinto et al., 2025).

2.3 Structural and Organizational Antecedents of Disengagement in Healthcare Work Environments

Understaffing emerges consistently across the literature as a structural antecedent of disengagement, associated not merely with transient strain but with burnout, job dissatisfaction, reduced engagement, and intention to leave (Lasater et al., 2025; Muir et al., 2025; Muir et al., 2026; Pindek et al., 2025). Higher patient-to-nurse ratios have been linked to poorer nurse job outcomes in hospital systems across multiple national contexts (Lasater et al., 2025; Muir et al., 2026), with each additional patient assigned associated with increased odds of burnout and departure in multi-state hospital data (Muir et al., 2025), and higher ratios independently associated with elevated occupational stress across measured domains (Chen et al., 2025). A Philippine health-workforce synthesis likewise identifies shortages, maldistribution, retention problems, and migration pressure as interconnected supply fragilities, showing how staffing strain can arise from system-level pipeline conditions (Atento, Quinto, & Espelita, 2025).

A second, closely related structural antecedent is moral distress, which the literature connects to withdrawal, reduced extra effort, burnout, and turnover intention through the compounding effect of organizational constraints on compromised care delivery (Boulton et al., 2023; Maunder et al., 2023; Ventovaara et al., 2023; Cerela-Boltunova et al., 2025). In intensive care settings, moral distress has been independently associated with intention to leave, accompanied by qualitative accounts of withdrawal from patients and families (Boulton et al., 2023), while in a separate intensive care sample, higher moral distress predicted reduced willingness to take on additional duties (Cerela-Boltunova et al., 2025)—a finding that maps closely onto the behavioral signature of quiet quitting described in Section 2.1. In pediatric oncology and psychiatric care settings, moral distress has similarly tracked resignation-oriented thinking and weakened retention signals (Ventovaara et al., 2023; Eder et al., 2025). A Philippine health-professions education review similarly identifies moral distress, role overload, burnout, and resource scarcity as interdependent pressures requiring systems-level interpretation (Bermido et al., 2025).

These two mechanisms appear to interact with broader organizational conditions rather than operating in isolation. Unsafe staffing, peak overload, resource constraints, weak ethical climates, and low team support have each been linked to disengagement pathways ranging from burnout and dissatisfaction to compromised teamwork and leaving intentions (Chen et al., 2025; Cerela-Boltunova & Millere, 2025; Booth & Robinson, 2025; Ventovaara et al., 2023; Miller et al., 2025). High-acuity settings such as intensive care appear especially vulnerable to distress-linked disengagement (Booth & Robinson, 2025; Cerela-Boltunova et al., 2025), while long-term care and emergency nursing reviews describe a pattern of broader workforce destabilization arising from lean staffing and distress-driven attrition (Miller et al., 2025; Boulton & Farquharson, 2023). Notably, supportive team relationships, ethical organizational culture, and visible organizational investment recur across studies as protective factors that moderate these structural pressures (Boulton et al., 2023; Fantus et al., 2024), foreshadowing the managerial responses examined later in this review. In a Philippine tertiary hospital, staffing, budget, and equipment constraints were the most frequently reported barriers to accreditation work, illustrating capacity-based rather than purely attitudinal implementation friction (Garcia & Atento, 2026).

2.4 Consequences of Workforce Disengagement for Healthcare Organizational Performance and Health-System Delivery

Disengagement is associated with measurable reductions in healthcare organizational performance. Physician burnout has been linked to substantially elevated job dissatisfaction and turnover intention alongside a smaller but significant loss in productivity (Hodkinson et al., 2022), while a systematic review of nursing studies found burnout consistently and inversely associated with organizational commitment and productivity (Jun et al., 2021). Staff engagement, conversely, has been linked to lower turnover and absenteeism, both of which bear directly on organizational functioning and safety (Janes et al., 2021), and burnout–turnover intention associations of medium magnitude have been reported specifically among nurses (Özkan, 2021). Evidence from South Korean hospital nurses reinforces this pattern bidirectionally: burnout, emotional exhaustion, and job stress predicted turnover intention, while engagement and organizational commitment predicted retention (Kim & Kim, 2021). A healthcare analytics framework similarly links organizational alignment and decision capability to coupled clinical and business outcomes, reinforcing the system-performance relevance of organizational conditions (Atento, Quinto, Espelita, & Castaneda, 2025).

The consequences of disengagement extend beyond organizational metrics into patient care quality. A meta-analysis found work engagement positively associated with quality of care ($r = .26$) (Wee & Lai, 2021), while a separate meta-analysis linked staff engagement to overall patient safety ($r = 0.22$) and to fewer errors and adverse events ($r = -0.20$) (Janes et al., 2021). Physician burnout has been associated with a doubling of patient safety incidents alongside reduced professionalism and patient dissatisfaction (Hodkinson et al., 2022), and nurse burnout has similarly been linked to worsening safety, care quality, and patient satisfaction (Jun et al., 2021). In Jordanian hospital data, workload, burnout, and turnover intention were each negatively related to healthcare quality, with job satisfaction functioning as a partial buffer (Alzoubi et al., 2024). Narrative health analytics likewise treats empathy, trust, and communication quality as signals that may require complementary indicators, highlighting limits of conventional dashboards for detecting subtle interpersonal erosion (Atento, Quinto, Espelita, & San Juan, 2025).

At the level of system delivery capacity, emotionally strained staff have been observed to disengage from empathic communication, teamwork, proactive problem-solving, and knowledge sharing—eroding trust and collective efficacy over time (Başal et al., 2026)—while high turnover has been shown to disrupt continuity of care and integrated practice, raising costs alongside compromising quality (Berhanu et al., 2026). Evidence specific to quiet quitting remains comparatively new and more indirect than the broader burnout literature, but reviews focused on hospital and nursing populations argue that reduced discretionary effort and extra-role contribution plausibly threaten care quality, patient safety, and workforce sustainability, even where direct patient-outcome studies specific to quiet quitting remain limited (Cesaro & Daicampi, 2026; Bakeet et al., 2024). This gap between the more established burnout–performance literature and the newer quiet-quitting-specific literature marks an important limitation to be addressed later in this review. In a maritime service setting, organizational practices and human factors were significantly associated with quality-system implementation and operational performance, offering a cross-sector analogue for organization-dependent service reliability (Gamasan & Atento, 2026).

2.5 Managerial and Organizational Responses to Disengagement in Healthcare Settings

The literature identifies two broad categories of organizational response, with differing levels of evidentiary certainty. Supportive leadership shows the most consistent association with higher engagement and lower disengagement-related outcomes across healthcare settings (Kim et al., 2023; Kohnen et al., 2024; Quek et al., 2021; Ghamdi & Alammari, 2025). Among Korean nurses, supportive nurse-manager leadership emerged as the strongest predictor of work engagement even after accounting for other resources (Kim et al., 2023), while among Belgian nurses, engaging leadership was linked to greater engagement and lower burnout through its effects on job resources and intrinsic motivation (Kohnen et al., 2024). Distributed and inclusive leadership approaches have similarly been associated with higher engagement, lower turnover intention, and reduced presenteeism, particularly when paired with strong perceived organizational support (Quek et al., 2021; Wang et al., 2024; Pattali et al., 2024; Ghamdi & Alammari, 2025).

A second category of response—organization-directed interventions targeting job resources, such as peer support structures, training, justice, and workload redistribution—shows a positive but more heterogeneous evidence base (Szilvassy & Širok, 2022; Kim et al., 2023; Ashfaq et al., 2023; Giallourous et al., 2023; Hamdan & Issa, 2021; Cohen et al., 2023; Boskma et al., 2025; Shiri et al., 2023). Peer support meetings have shown favorable effects on

engagement in organization-directed studies (Boskma et al., 2025), and workload reduction and job-crafting strategies recur across intervention reviews (Cohen et al., 2023), with leadership also functioning indirectly to raise engagement by improving training, supervision, and shared organizational vision (Giallourous et al., 2023). However, reviewers caution that intervention findings remain mixed, that many underlying studies carry design weaknesses, and that some programs yield neutral or even adverse outcomes when poorly matched to local organizational needs (Cohen et al., 2023; Boskma et al., 2025; De Vries et al., 2023). Among helping professionals, resilience-related psychological resources were associated with perceived professional effectiveness, supporting individual capacity-building as a complement—not a substitute—for structural remediation (Adame, 2026).

Across both categories, a recurring mechanism links managerial response to workforce outcomes: leadership and resource-based interventions appear to operate substantially by increasing perceived organizational support, autonomy, cohesion, justice, and meaning at work (Sanseverino et al., 2026; Ashfaq et al., 2024; Zhang et al., 2025; Zhao et al., 2024). This mechanism-level convergence suggests that managerial responses to disengagement in healthcare settings are most effective when they address the underlying demand–resource imbalance identified in Section 2.2, rather than treating disengagement as an isolated attitudinal problem to be corrected through individual-level coping interventions alone.

2.6 Synthesis of Literature

Across the five themes, the literature converges on several points. First, quiet quitting is increasingly treated as a conceptually distinct phenomenon—deliberate, boundary-setting, and behaviorally circumscribed—rather than a synonym for burnout, cynicism, or turnover intention, even though these constructs frequently co-occur and share antecedents (Section 2.1). Second, Job Demands–Resources theory offers a consistent explanatory mechanism for disengagement broadly, with the imbalance between demands and resources, rather than demand level alone, identified as the operative driver (Section 2.2). Third, healthcare-specific structural conditions—understaffing and moral distress in particular—recur across multiple care settings as antecedents of withdrawal, with organizational culture and team support functioning as moderating, protective factors (Section 2.3). Fourth, disengagement broadly construed carries measurable consequences for organizational performance, patient safety, and system-level delivery capacity, with effect sizes reported across several meta-analyses (Section 2.4). Fifth, managerial responses—particularly supportive leadership—show the most consistent evidentiary support for mitigating disengagement, while resource-based organizational interventions show positive but more heterogeneous effects (Section 2.5).

The literature also converges on an important structural point that carries direct thesis relevance: several sources across Sections 2.1 and 2.3 explicitly resist individual-blame framings, instead treating disengagement—and moral distress-driven withdrawal specifically—as arising from organizational constraints, resource limitations, and compromised agency rather than individual motivational deficit. This convergence lends direct support to the paper’s central thesis that quiet quitting in healthcare is better understood as a structurally induced response than as an individual failing.

At the same time, a consistent limitation runs through the body of evidence: the great majority of studies establishing mechanisms (Theme 2), antecedents (Theme 3), consequences (Theme 4), and responses (Theme 5) measure burnout, engagement, or turnover intention as their outcome variables—not quiet quitting itself. The quiet-quitting-specific literature (Theme 1, and portions of Themes 4–5) is newer, smaller, and largely acknowledges this indirectness explicitly (Cesaro & Daicampi, 2026; Bakeet et al., 2024). The literature therefore establishes the surrounding architecture of the phenomenon more firmly than it establishes the phenomenon’s own empirical footprint in healthcare settings.

2.7 Gaps in the Literature

Several gaps follow from this synthesis. First, there is a persistent construct-to-outcome linkage gap: while JD-R mechanisms, structural antecedents, and managerial responses are well evidenced for burnout, exhaustion, and turnover intention, few studies test these same relationships with quiet quitting—specifically its defining features of deliberate boundary-setting and minimum-compliance behavior—as the measured outcome. Second, an unresolved definitional boundary remains regarding whether reduced organizational citizenship behavior belongs inside the definition of quiet quitting or should be modeled as one of its downstream consequences (Gray et al., 2025; Sugaguil et al., 2026); this ambiguity has direct consequences for how the construct should be operationalized in future

healthcare-specific research. Third, the literature shows a professional-group concentration gap: the healthcare-specific evidence base is weighted heavily toward nursing populations, with comparatively little attention to physicians, allied health professionals, and other high-demand healthcare roles, limiting the generalizability of structural-antecedent findings across the healthcare workforce. Fourth, there is a measurement maturity gap: quiet-quitting-specific scales remain recent and still under validation (Patel et al., 2025; Karrani et al., 2023), meaning that healthcare-specific empirical findings using these instruments remain limited relative to the more established burnout and engagement literatures. Fifth, the consequence literature (Theme 4) exhibits a direct-evidence gap specific to quiet quitting: while disengagement broadly is linked to patient safety and care quality through substantial meta-analytic evidence, the corresponding link for quiet quitting specifically is argued rather than directly demonstrated, a limitation multiple authors acknowledge explicitly. Finally, the managerial-response literature (Theme 5) reveals an intervention-targeting gap: leadership and resource interventions have been tested against engagement and burnout outcomes, but not against quiet quitting as a distinct behavioral target, leaving open whether interventions effective against exhaustion-based disengagement are equally effective against the more deliberate, boundary-setting pattern that defines quiet quitting.

2.8 Contribution of the Present Paper

The present paper addresses these gaps conceptually rather than empirically, by constructing the theoretical bridge that the existing literature builds toward but does not yet complete. Specifically, it integrates the definitional architecture of quiet quitting (Section 2.1) with the demand–resource mechanism established for disengagement broadly (Section 2.2) and the healthcare-specific structural antecedents of understaffing and moral distress (Section 2.3), to propose that quiet quitting in high-demand healthcare professions can be conceptually modeled as a structurally induced calibration response to sustained demand–resource imbalance—distinct from, but proximate to, the exhaustion-based and exit-based pathways already well documented in the literature. In doing so, the paper offers healthcare management scholarship a conceptual framework for interpreting quiet quitting as an organizational signal of resource inadequacy rather than an individual disciplinary or motivational concern, with corresponding implications for how managerial responses (Section 2.5) might be reoriented toward structural rather than purely individual-level intervention. This conceptual contribution does not resolve the empirical gaps identified above but is positioned to inform the design of future research capable of doing so.

3. Methodology

This paper adopts a conceptual, integrative literature-synthesis design. It is not an empirical study, and no primary data—survey responses, interview transcripts, or observational records—were collected or analyzed. The paper’s purpose is instead to construct a theoretical account of quiet quitting in high-demand healthcare professions by integrating existing literature on the construct itself with adjacent bodies of theory and evidence concerning occupational demands, structural antecedents of disengagement, and organizational consequences and responses. The method is best described as a structured, thematically organized conceptual review rather than a systematic or scoping review in the formal methodological sense; no database-specific search protocol, screening flow diagram, inter-rater reliability procedure, or formal inclusion/exclusion coding scheme was applied, and no such procedures are claimed.

Source orientation. The literature informing this paper was retrieved through targeted, theme-directed searches designed to surface peer-reviewed evidence relevant to five conceptually distinct but interrelated questions: how quiet quitting is defined and differentiated from adjacent constructs; how job demands and resources theoretically produce disengagement; what structural and organizational conditions give rise to disengagement in healthcare settings specifically; what consequences disengagement holds for organizational performance and care delivery; and what managerial responses the literature associates with mitigating disengagement. Search questions were formulated in a yes/no, literature-searchable format for each theme and used to guide retrieval through a research-literature search tool. The resulting body of literature spans concept analyses, scoping reviews, systematic reviews, meta-analyses, and empirical studies published predominantly in nursing, health services, and organizational-psychology journals.

Source-selection and inclusion logic. Sources were included where they directly addressed one of the five guiding themes and originated from peer-reviewed journals identifiable through the search tool’s indexing. Priority was given to reviews, meta-analyses, and theory papers where available, supplemented by primary empirical studies where they offered theme-specific evidence not otherwise captured by higher-order syntheses—for example, empirical studies linking specific structural conditions (patient-to-nurse ratios, moral distress indices) to disengagement-related

outcomes in defined healthcare settings. Sources addressing quiet quitting outside healthcare contexts were retained where they contributed to definitional or mechanistic clarity (Section 2.1), consistent with the paper's aim of situating the healthcare-specific phenomenon within its broader conceptual lineage. No sources were excluded on the basis of findings running contrary to the paper's thesis; where the literature offered qualifying or contrary evidence—such as the observation that high demands do not invariably suppress engagement under strong-resource conditions—this was retained and reported rather than omitted.

Thematic organization. The five themes were sequenced to move from foundational definitional work, through explanatory mechanism, into healthcare-specific structural context, toward organizational consequences, and finally toward managerial response—an architecture intended to build the conceptual case incrementally rather than to present parallel, disconnected bodies of evidence. This sequencing itself constitutes part of the paper's analytical contribution, since the literature as retrieved does not arrive pre-organized into this progression; the thematic architecture reflects an interpretive choice made to support the paper's central thesis regarding structurally induced disengagement.

Theoretical framework. Job Demands–Resources (JD-R) theory serves as the primary interpretive lens applied across the literature synthesis, given its explicit theoretical role in the retrieved evidence (Section 2.2) and its capacity to connect structural antecedents (Section 2.3) to disengagement outcomes (Sections 2.1, 2.4) through a single explanatory mechanism. This lens is applied interpretively rather than tested statistically; no JD-R measurement instrument was administered, and no quantitative model was estimated.

Analytical and synthesis procedure. Analysis proceeded through iterative comparison across sources within and between themes, identifying points of convergence (e.g., the consistent separation of quiet quitting from burnout), points of unresolved debate (e.g., whether reduced organizational citizenship behavior belongs within the construct's definition), and points where the evidence base for quiet quitting specifically remains thinner than the evidence base for related constructs such as burnout and turnover intention. These patterns were then synthesized into the higher-order conceptual argument developed in Section 4, which extends beyond literature summary to propose a structural interpretation of quiet quitting in healthcare settings.

Limitations. As a conceptual synthesis, this paper does not test its proposed framework against original data, and the conclusions drawn remain theoretical propositions rather than empirically validated findings. The underlying literature is also unevenly distributed across healthcare professions, with nursing populations considerably overrepresented relative to physicians and allied health professionals, a limitation that constrains the generalizability of any healthcare-specific claims advanced in this paper. Finally, because much of the demand–resource and structural-antecedent evidence measures burnout, engagement, or turnover intention rather than quiet quitting directly, the conceptual bridge constructed in this paper necessarily involves interpretive extension beyond what the cited literature demonstrates outright—a distinction maintained explicitly throughout the analysis that follows.

4. Analytical Synthesis / Conceptual Analysis and Discussion

4.1 Repositioning Quiet Quitting as a Calibration Response

The literature reviewed in Section 2 supports a conceptual repositioning of quiet quitting in high-demand healthcare professions: rather than treating it as an individual attitudinal failure, a moral lapse, or a synonym for burnout, it can be more precisely understood as a calibrated behavioral response to a sustained imbalance between occupational demands and available organizational resources. Job Demands–Resources theory establishes the general mechanism by which such imbalance produces disengagement (Section 2.2), while the healthcare-specific evidence on understaffing and moral distress (Section 2.3) identifies the particular structural conditions under which this imbalance becomes chronic rather than episodic in care settings. What the definitional literature on quiet quitting adds to this picture (Section 2.1) is the observation that the resulting behavioral adjustment is not merely a passive symptom of strain but an active, bounded, and often deliberate recalibration of effort—one in which the healthcare professional continues to meet formal role obligations while withdrawing the discretionary contribution that healthcare delivery has historically depended upon informally.

This repositioning carries an important interpretive consequence. If quiet quitting were simply a milder variant of burnout, it would be reasonable to treat it as an early-warning symptom to be addressed through the same individual-focused interventions—resilience training, coping-skills programs, wellness initiatives—that are commonly directed

at burnout. The literature synthesized here suggests otherwise. Because quiet quitting is characterized by deliberate boundary-setting rather than exhaustion-driven collapse, and because it can occur independently of the cynicism and depersonalization that typically accompany burnout (Patel et al., 2025), it functions less as a health symptom and more as a rational, self-protective adjustment to a persistently unfavorable demand–resource ratio. Understood this way, quiet quitting behaves less like an illness to be treated in the individual and more like a pressure gauge reading on the organization itself—a visible indicator that the structural conditions of the work environment have shifted the calculus of discretionary effort for a meaningful share of the workforce.

4.2 A Conceptual Pathway Model

The literature reviewed supports a staged conceptual pathway linking structural conditions to organizational consequence, which this paper terms the Demand–Resource Calibration Pathway. The pathway proceeds through four conceptually distinct stages.

The first stage is structural exposure, in which healthcare professionals operate under conditions of chronic demand intensity—elevated patient loads, emotional labor, and moral load arising from resource-constrained care environments (Section 2.3). This stage is distinguished from acute or episodic overload by its persistence: the evidence on understaffing and moral distress describes recurring, structurally embedded conditions rather than isolated incidents.

The second stage is appraisal and calibration, in which the healthcare professional, rather than exiting the organization or succumbing to exhaustion-driven withdrawal, adjusts the boundary of discretionary contribution to align more closely with the resources the organization has made available. This stage draws directly on the definitional literature’s emphasis on deliberateness and boundary-setting (Section 2.1) and distinguishes the pathway from a purely exhaustion-based model: the professional retains functional capacity but redirects it away from extra-role contribution.

The third stage is behavioral manifestation, corresponding to the observable signature of quiet quitting identified across the literature—reduced organizational citizenship behavior, diminished initiative, withdrawal from informal leadership and mentorship, and reduced willingness to absorb coverage gaps (Sections 2.1, 2.3). It is at this stage that quiet quitting becomes visible to the organization, typically before it manifests as formal turnover or diagnosable burnout.

The fourth stage is organizational consequence, in which the aggregation of individual calibration responses across a workforce produces measurable erosion in organizational performance, care quality, and system-level delivery capacity, consistent with the consequence literature reviewed in Section 2.4.

The analytical value of this pathway lies in what it implies about intervention timing. Because behavioral manifestation (Stage 3) precedes the more severe and costly outcomes captured in Stage 4—and because it is conceptually and empirically distinguishable from burnout and turnover intention—quiet quitting can be understood as an intermediate, potentially reversible signal rather than a terminal state. This reframes the phenomenon from an outcome to be managed after the fact into a diagnostic indicator that organizations might, in principle, learn to read earlier than conventional burnout or exit metrics allow.

4.3 Distinguishing Quiet Quitting Along Two Conceptual Axes

The definitional literature’s persistent effort to separate quiet quitting from burnout, cynicism, and turnover intention (Section 2.1) can be organized more systematically along two conceptual axes: an exit axis, ranging from remaining in the role to formally leaving it, and an intentionality axis, ranging from passive, exhaustion-driven withdrawal to deliberate, boundary-setting calibration.

Positioned along these axes, burnout occupies a region of remaining-but-depleted: the professional stays in role, but withdrawal is driven by exhaustion rather than deliberate choice. Turnover intention occupies a region of intending-to-exit, positioned toward the exit axis regardless of whether the underlying motivation is exhaustion or dissatisfaction. Organizational cynicism occupies a region closer to passive psychological distancing, involving meaning loss without necessarily involving deliberate effort restriction. Quiet quitting, by contrast, occupies a distinct region: remaining in role, but with withdrawal that is comparatively deliberate and bounded rather than exhaustion-driven.

This two-axis positioning offers an analytical resolution to the debate identified in Section 2.7 regarding whether reduced organizational citizenship behavior belongs within the definition of quiet quitting or should be treated as its consequence. Understood through the intentionality axis, citizenship withdrawal that arises from deliberate boundary-setting is more properly definitional of quiet quitting, while citizenship withdrawal that arises from exhaustion-driven depletion is more properly a consequence of burnout operating through a different mechanism. The practical implication is that healthcare organizations observing reduced discretionary contribution among staff cannot assume a single underlying cause; the same surface behavior may reflect either calibrated withdrawal or exhaustion-driven collapse, with materially different implications for the appropriate managerial response.

4.4 Conceptual Propositions

From the pathway model and the two-axis positioning developed above, this paper advances three conceptual propositions intended to clarify testable relationships for future empirical inquiry, while remaining explicit that they are proposed rather than demonstrated by the literature reviewed here.

Proposition 1: The likelihood and intensity of quiet quitting among healthcare professionals varies with the chronicity, rather than merely the magnitude, of demand–resource imbalance; sustained structural imbalance is expected to produce calibrated withdrawal, whereas acute but time-limited imbalance is more likely to produce transient strain without durable behavioral recalibration.

Proposition 2: Quiet quitting and burnout represent divergent, though not mutually exclusive, pathways from a common structural antecedent (demand–resource imbalance), with the two pathways distinguished by the degree of perceived agency retained by the healthcare professional; where perceived agency remains intact, calibration (quiet quitting) is the more likely response, whereas where perceived agency is severely constrained—as in high moral-distress environments—exhaustion-driven withdrawal (burnout) is the more likely response.

Proposition 3: Because quiet quitting behaviorally manifests prior to formal turnover and independently of clinical burnout symptomatology, it functions as an earlier and organizationally actionable signal of demand–resource imbalance than either turnover statistics or burnout prevalence, and healthcare organizations that monitor discretionary–effort indicators are positioned to intervene at an earlier stage of workforce strain than those relying solely on exit or exhaustion metrics.

These propositions are conceptual rather than empirically confirmed; they are offered as a structured basis for future measurement and testing rather than as established findings.

4.5 Organizational and Performance Implications of the Framework

The pathway model developed in Section 4.2 provides an interpretive bridge to the consequence literature reviewed in Section 2.4. If quiet quitting functions as an intermediate calibration response rather than a terminal outcome, then the organizational performance and care-quality consequences documented for disengagement more broadly—reduced productivity and commitment, elevated safety incidents, weakened continuity of care—can be understood not as inevitable outcomes of individual employee choices, but as downstream effects of an unaddressed structural imbalance that first became visible, and arguably addressable, at the point of behavioral manifestation. This reframing shifts analytical attention away from questions of individual employee commitment and toward questions of organizational design: staffing adequacy, workload distribution, and the structural sources of moral distress identified in Section 2.3.

The managerial-response literature reviewed in Section 2.5 lends further support to this structural interpretation. The comparatively strong and consistent evidence supporting supportive leadership as a mitigating factor, and the more heterogeneous but still positive evidence for resource-based organizational interventions, both point toward interventions that operate on the resource side of the demand–resource ratio rather than on individual coping capacity alone. Within the framework developed here, this pattern is consistent with the proposition that quiet quitting responds more readily to structural remediation—restored resources, redistributed workload, strengthened organizational support—than to interventions aimed at increasing individual resilience to unchanged demand conditions. This does not imply that individual-level support has no role; rather, it suggests that such support is likely to be necessary but insufficient where the underlying demand–resource imbalance remains structurally unaddressed.

4.6 Boundary Conditions of the Framework

The framework advanced in this section is subject to several boundary conditions that limit its scope. First, the pathway model assumes a degree of retained professional agency at the appraisal stage; in healthcare contexts characterized by extreme moral distress or severely constrained agency, the literature reviewed in Section 2.3 suggests that exhaustion-driven pathways may dominate over calibrated withdrawal, placing such contexts closer to a burnout-dominant rather than a quiet-quitting-dominant pattern. Second, the framework is derived primarily from literature concentrated in nursing populations, and its applicability to physicians, allied health professionals, and administrative healthcare staff should be regarded as a conceptual extension rather than an evidenced claim, consistent with the professional-group concentration gap identified in Section 2.7. Third, because the propositions advanced in Section 4.4 have not been tested against original data, they should be treated as a structured research agenda rather than as established relationships; their value at this stage lies in organizing existing evidence into a coherent, testable architecture rather than in resolving open empirical questions.

5. Discussion and Implications

5.1 Theoretical Implications

The conceptual account developed in this paper contributes to healthcare workforce scholarship by resolving an ambiguity that has persisted across recent literature: whether quiet quitting should be theorized as a variant of burnout, a precursor to turnover, or a distinct phenomenon in its own right. By positioning quiet quitting along the intentionality and exit axes developed in Section 4.3, this paper offers a more precise theoretical vocabulary for future healthcare workforce research—one that treats deliberate, bounded effort withdrawal as analytically separable from exhaustion-driven depletion, even as the two frequently share structural origins. This distinction carries implications beyond terminology. Theoretical models that treat disengagement as a single undifferentiated construct risk obscuring the divergent pathways identified in Proposition 2: where perceived professional agency remains intact, calibration rather than exhaustion may be the dominant response to demand–resource imbalance. Future theoretical work on healthcare workforce sustainability would benefit from incorporating this agency-contingent branching explicitly, rather than treating disengagement outcomes as interchangeable indicators of a single underlying strain process.

5.2 Implications for Healthcare Organizations and Management Practice

The Demand–Resource Calibration Pathway developed in Section 4.2 carries direct implications for how healthcare organizations interpret early signals of workforce strain. Because quiet quitting behaviorally manifests prior to formal turnover and independently of diagnosable burnout, organizations that rely primarily on exit interviews, turnover statistics, or clinical burnout screening as their principal workforce-monitoring tools may be systematically detecting strain later than the evidence reviewed here suggests is possible. Indicators more proximate to Stage 3 of the pathway—declining voluntary participation in quality-improvement activities, reduced uptake of optional shifts or mentorship roles, diminished engagement in informal coverage arrangements—may offer healthcare organizations a more timely diagnostic window than conventional metrics allow, consistent with Proposition 3.

The framework also carries implications for how healthcare organizations calibrate their response once such signals are observed. The managerial-response literature reviewed in Section 2.5 indicates that supportive leadership and resource-directed interventions show the strongest association with mitigating disengagement, a pattern consistent with this paper’s structural interpretation of quiet quitting as a response to demand–resource imbalance rather than an individual deficit. This suggests that healthcare organizations observing quiet-quitting-consistent behavior among staff would be better served by examining staffing adequacy, workload distribution, and sources of moral distress within the affected unit than by directing resources toward individual-focused resilience or engagement programming alone—though, as noted in Section 4.5, individual-level support retains value as a complement to, rather than a substitute for, structural remediation.

5.3 Implications for Health Systems and Health Policy

At the system level, the framework developed in this paper suggests that workforce disengagement operating through the calibration pathway may represent an underrecognized structural risk to care continuity and health-system delivery capacity, distinct from and potentially preceding the more visible risks associated with staff attrition. Insofar

as staffing-adequacy policy has historically been evaluated primarily against attrition and burnout prevalence, this paper's conceptual argument suggests that policy frameworks concerned with health-system workforce sustainability might also benefit from attention to discretionary-effort indicators as a leading, rather than lagging, measure of workforce strain. This has particular relevance for staffing-ratio and workload-regulation policy, where the evidence reviewed in Section 2.3 links structural staffing conditions directly to disengagement pathways; policy instruments designed primarily to prevent burnout or reduce turnover may not adequately capture the calibration-based withdrawal this paper describes, since such withdrawal can occur among staff who are neither clinically exhausted nor actively seeking to leave.

5.4 Implications for Health-Related Outcomes

The consequence literature reviewed in Section 2.4 links workforce disengagement broadly to reduced patient safety and diminished care quality. Extended through this paper's framework, this suggests that the aggregate health-related consequences of quiet quitting may accumulate gradually and diffusely—through incremental reductions in teamwork, mentorship, and discretionary vigilance—rather than through the more abrupt disruptions associated with staff departure. This diffuse accumulation pattern may make quiet-quitting-driven erosion in care quality comparatively difficult to detect through conventional incident-reporting or safety-monitoring systems, which are typically calibrated to capture discrete events rather than gradual shifts in discretionary engagement.

5.5 Theoretical Boundaries and Limitations

The implications outlined above are bounded by the limitations acknowledged in Section 4.6: the framework rests on a conceptual extension from a literature base concentrated in nursing populations, and the propositions advanced remain untested against original data. The paper's claims regarding health-related outcomes in particular should be read as plausible extensions of the demand–resource framework rather than as evidenced conclusions, given the direct-evidence gap identified in Section 2.7 between disengagement broadly and quiet quitting specifically. These boundaries do not diminish the framework's conceptual utility but do constrain the strength of the implications drawn from it, pending future empirical validation.

6. Conclusions and Recommendations

This paper set out to address an unresolved conceptual problem in healthcare workforce scholarship: the absence of a coherent theoretical account distinguishing quiet quitting from burnout and turnover intention within high-demand healthcare professions, and the corresponding risk of treating a structurally induced disengagement pattern as an individual motivational failing. Drawing on literature spanning the definitional architecture of quiet quitting, Job Demands–Resources theory, healthcare-specific structural antecedents of disengagement, organizational consequences of workforce disengagement, and managerial responses to it, this paper has argued that quiet quitting in healthcare settings is better understood as a deliberate, bounded calibration response to sustained demand–resource imbalance than as an exhaustion-driven symptom or an individual disciplinary concern.

The strongest insight to emerge from this synthesis is the distinction between calibration-based and exhaustion-based disengagement pathways, organized in this paper along axes of exit and intentionality. This distinction clarifies why quiet quitting can occur independently of clinical burnout symptomatology and why it may be more responsive to structural remediation—restored staffing adequacy, redistributed workload, strengthened organizational support—than to individual-focused resilience interventions alone. The Demand–Resource Calibration Pathway developed in this paper further suggests that quiet quitting behaviorally manifests earlier than formal turnover or diagnosable burnout, positioning it as a potentially actionable, intermediate signal of workforce strain rather than a terminal outcome to be managed only after it has occurred.

These insights remain conceptual propositions rather than empirically confirmed relationships. The literature underlying this synthesis is concentrated disproportionately in nursing populations, and the mechanisms linking demand–resource imbalance, structural antecedents, and disengagement outcomes have been established predominantly for burnout and turnover intention rather than for quiet quitting directly. The three propositions advanced in Section 4.4—concerning chronicity of imbalance, agency-contingent pathway divergence, and the earlier-signal function of quiet quitting relative to turnover and burnout metrics—are offered as a structured basis for future

empirical inquiry rather than as validated findings, and the framework as a whole should be read as a conceptual model awaiting testing rather than a confirmed account of causal mechanism.

Several recommendations follow with appropriate proportionality to this conceptual status. For healthcare management practice, organizations may benefit from incorporating discretionary-effort and citizenship-behavior indicators alongside conventional turnover and burnout metrics when assessing workforce strain, given this paper's argument that such indicators may surface earlier in the disengagement pathway. For healthcare organizational design, the framework suggests that responses to observed disengagement should first examine staffing adequacy, workload distribution, and sources of moral distress before defaulting to individual-focused engagement or resilience programming, consistent with the structural interpretation advanced throughout this paper. For future empirical research, priority should be given to testing whether quiet-quitting-specific measurement instruments—as they continue to mature—predict the organizational and care-quality outcomes examined in this paper independently of burnout and turnover intention, and to extending the evidence base beyond nursing populations to physicians, allied health professionals, and other high-demand healthcare roles. Longitudinal designs capable of testing the chronicity-contingent relationship proposed in Proposition 1, and comparative designs capable of testing the agency-contingent branching proposed in Proposition 2, represent particularly promising directions for advancing this research agenda empirically.

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