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Factors Associated with the Quality of Work Life in Doctors at Hospitals in Loja

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Abstract

Stress, work overload, and organizational climate affect the performance of healthcare personnel and hinder work environment improvement. This study aimed to identify factors associated with the perception of quality of work life (QOL) in hospitals in southern Ecuador. A quantitative, analytical, and cross-sectional study was conducted with 134 physicians, using the short version of the QOL-GOHISALO questionnaire to assess QOL. Perceptions of QOL were found to be low (mean: 80.87 ± 17.56), in contrast to the theoretical mean. Significant differences were found based on academic level, work schedule, psychological and/or neurological disorders, self-perceived health, and parenting. The QOL of healthcare personnel is low and is influenced by sociodemographic, occupational, family, and health factors.

Keywords: *Quality of Work Life, Healthcare Personnel, Well-Being; Satisfaction.*

Introduction

Health is a fundamental pillar for people's well-being and development. Promoting and maintaining good health will guarantee people a better quality of life and greater development, and the participation of healthcare workers is crucial to this (1). According to the World Health Organization [WHO], a health worker is a professional dedicated to improving health through direct care to people or through support functions in care (2). Statistics show the presence of more than 59 million health workers globally, a figure demonstrating their importance in the different health systems; however, many of these workers are constantly exposed to factors that compromise their well-being and safety during their work time (2).

A group of professionals whose work demands special commitment is the medical community. Their activities, directly related to illness and the care of people, are carried out in complex and highly specialized contexts (1–3), demanding to be supported by scientific, technological and/or administrative advances, which generates a high level of demand that will impact not only their quality of life, but also their professional performance and consequently the quality of care they offer (4), sometimes leading to adverse consequences for those who provide care, as a result of the provision of inadequate services, which is known as the "second victim" concept (5).

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In this context, quality of working life [QWL] is a determining and complex factor by its very definition. Due to its multifactorial nature (6), your conceptualization is diverse; however, there is a tacit agreement to relate it to the satisfaction of basic parameters such as recognition, motivation, security, the balance between work and family, and job stability within a formal and paid job (7–9). Achieving a suitable work environment that promotes employee well-being, improves patient safety, and the quality of care (10) requires sufficient infrastructure and resources and a healthy work environment based on compliance with ethical principles and labour regulations (11).

Among the many factors that can affect the quality of life of physicians, work-related stress is a significant factor resulting from the combination of other factors, such as exhausting work hours, pressure to make decisions, fear of making mistakes, exposure to verbal or physical abuse, and role conflict. In addition to reducing professional satisfaction, these factors can cause fatigue that compromises performance and professional retention (5,12). Dolev et al. (13) in 2022, showed that long working hours caused a significant decrease in physicians' attention, reflecting a deterioration in their response and care capacity (14,15). These findings coincide with a study by the International Labor Organization (ILO) on the health sector in Ecuador, which identified that work overload, lack of incentives, and limited availability of supplies hinder adequate care and affect staff performance (16).

For its part, organizational climate is recognized as a key factor in the effectiveness and performance of healthcare personnel, due to its direct influence on employee behaviour, motivation, and performance. A favourable work environment fosters cohesion, efficiency, and goal achievement, while an adverse one can generate demotivation and diminish service quality (12,17). Thus, ensuring an adequate quality of work life impacts workers' well-being and strengthens organizational performance by promoting trust and mutual respect within health institutions (10,18,19).

Since healthcare depends mainly on the commitment and stability of human resources, this research aims to identify the factors associated with the perception of quality of work life among healthcare staff in Loja hospitals. Understanding these factors will allow for the design of strategies to optimize their performance and, consequently, improve the quality of care provided to patients (20). The study was based on the theoretical model of González Baltazar et al. (21), which establishes that QWL is consolidated when workers experience satisfaction through institutional support, job security, integration into their environment, and recognition in their workplace. It also emphasizes that well-being at work depends not only on professional activity, but also on personal development and proper management of free time.

Materials and Methods

This study adopted a quantitative, analytical, and cross-sectional approach. The study population comprised 134 physicians from two public hospitals in Loja, Ecuador. Physicians working at these hospitals were included in the study. They freely and voluntarily agreed to participate, signing informed consent. The project was approved by the Ethics Committee of the University of Cuenca with code 2023-016EO-IE.

For the assessment of QWL, the short version of the 31-item CVT-GOHISALO questionnaire (22) was implemented. It uses a Likert-type scale from 0 to 4, depending on the level of satisfaction. The maximum total score is detailed in Table 1 according to the number of items per dimension.

Dimensions	Dimensions of Quality of Working Life		
	Low	Medium	High
Institutional support for work	< 12	12 to 16	> 17
Safety at work	< 8	8 to 12	> 13
Integration into the workplace	< 9	9 to 10	> 11
Job satisfaction	< 19	19 to 21	> 22
Well-being achieved through work	< 20	20 to 21	> 22
Personal development of the worker	< 8	8 to 10	> 11
Free time management	< 6	6 to 7	> 8
Total QWL	< 83	83 to 97	> 97

Table 1. Scores To Evaluate the Quality of Work Life According to the CVT-GOHISALO Questionnaire, Shortened Version.

Note. Taken from Pando Moreno et al. (2018).

Sociodemographic, occupational, family, and health variables were collected using a self-developed instrument. Family functioning was assessed using the family APGAR, which had a Cronbach's alpha reliability of 0.86 (23). Data was collected between December 2023 and March 2024, using online forms (Microsoft Forms) and physical surveys.

Descriptive statistics were used for qualitative variables and measures of central tendency for quantitative variables for univariate analysis. To identify factors associated with QoL, dependency analysis was applied using the Student T test for independent samples, the Mann-Whitney U test for dichotomous variables, and the Kruskal-Wallis test for variables with more than two groups. The analysis was performed using SPSS version 27 software (licensed by the Universidad Técnica Particular de Loja).

Results

The identification of sociodemographic, occupational, and health factors (Table 2) of the study population (n = 134) shows a higher prevalence of women (51.5%), with a general average age of 36.25 ± 7.77.

Regarding academic attainment, 59% of the population has a fourth-level education, with 29.9% holding a master's degree and 29.1% having a specialty. Additionally, 38.8% have earned a third-level bachelor's degree, while the doctorate represents the lowest percentage, at just 2.2%.

Regarding the role performed within the institution, the most representative group corresponds to the hospitalization area (38.10%), followed by emergency services (23.9%) and outpatient consultation (14.90%). Based on the classification of public servants related to the remuneration received (24), 51.5% of the participants belong to public servant group 7, which has a monthly income of $1,676.

Regarding health, 57.5% of participants reported having at least one diagnosed chronic condition. Among these, mental health disorders, including depression and/or anxiety, were the most common (23.1%), followed by neurological (16.4%) and musculoskeletal (15.7%) disorders. To a lesser extent, metabolic diseases, such as obesity, were identified and present in 13.4% of the study population.

Variable		Frequency (F)	Percentage (%)	Confidence Itervals (95%)
Age	$\bar{x}$ 36.25 ± 7.77			
Gender	Male	65	48.5	40.03 - 56.96
	Female	69	51.5	43.03 - 59.96
Type of health provider	MSP	54	40.3	31.99 - 48.60
	IESS	80	59.7	51.39 - 68.00
Academic level	Third level (undergraduate)	52	38.8	30.54 - 47.05
	Fourth level (master's degree)	40	29.9	22.14 - 37.65
	Fourth level (medical specialization)	39	29.1	21.40 - 36.79
	Doctorate (PhD)	3	2.2	14.98 - 29.01
Service area	Emergency	32	23.90	16.67 - 31.12
	Hospitalization	51	38.10	29.87 - 46.32
	Outpatient	20	14.90	8.87 - 20.82
	Other	18	13.40	7.63 - 19.16
Chronic illness	Without disease	57	42.5	34.13 - 50.86
	With disease	77	57.5	49.13 - 65.86
Main diseases				
	Depression and/or anxiety	31	23.1	15.96 - 30.23
	Neurological disorders	22	16.40	10.13 - 22.66
	Musculoskeletal disorders	21	15.7	9.54 - 21.85
	Obesity	18	13.4	7.63 - 19.16
	Other	36	26.9	19.39 - 34.40
Public servant category (SP)	SP 6 ($1412 USD)	3	2.2	0.00 - 4.68
	SP 7 ($1676 USD)	69	51.5	43.03 - 59.96
	SP 8 ($1760 USD)	2	1.5	0.00 - 3.55
	SP 9 ($2034 USD)	13	9.7	4.68 - 14.71
	SP 10 ($2308 USD)	4	3	0.11 - 5.88
	SP 11 ($2358 USD)	1	0.7	0.00 - 2.11
	SP 12 ($2408 USD)	42	31.3	23.44 - 39.15

Table 2. Characterization of the Study Population

The QWL was assessed using the short version of the CVT-GOHISALO instrument, which consists of seven dimensions (Table 3). The average value of each category was considered to

identify QWL based on the dimensions proposed by the model. It was observed that integration into the workplace (mean: 8.31 ± 2.15), job satisfaction (mean: 14.46 ± 4.11), well-being achieved through work (mean: 18.42 ± 3.04), and free time management (mean: 5.32 ± 2.07) were classified as low. Job security (mean: 11.13 ± 3.78), personal development (mean: 8.62 ± 2.19), and institutional support for work (mean: 14.6 ± 5.24) were associated with a medium-level perception of QWL, indicating relative stability in these aspects. No category had a high perception of QWL. Overall, total QWL was low in 46.3% of participants, with a mean of 80.87 ± 17.56.

Dimensions	**Low**	**Medium**	**High**	$\bar{x}$	**σ**
	N (%)	**N (%)**	**N (%)**		
Institutional support for work	36 (26.9%)	36 (26.9%)	62 (46.3%)	14.6	5.24
Safety at work	21 (15.7%)	72 (53.7%)	41 (30.6%)	11.13	3.78
Integration into the workplace	66 (49.3%)	49 (36.6%)	19 (14.2%)	8.31	2.15
Job satisfaction	115 (85.8%)	10 (7.5%)	9 (6.7%)	14.46	4.11
Well-being achieved through work	77 (57.5%)	45 (33.6%)	12 (9.0%)	18.42	3.04
Personal development of the worker	38 (28.4%)	67 (50%)	29 (21.6%)	8.62	2.19
Free time management	54 (40.3%)	55 (41%)	25 (18.7%)	5.32	2.07
Total QWL	62 (46.3%)	52 (36.6%)	20 (17.2%)	80.87	17.56

Table 3. Work-Life Quality Perception

In the bivariate analysis (Table 4), although men perceived a higher QWL, the difference between sexes was not statistically significant (p = 0.310). Similarly, although there was a lower perception of QWL in younger individuals ($\bar{x}$: 75.74 ± 21.31 in those under 30 vs. $\bar{x}$: 84.63 ± 15.16 in those over 30), this difference was not statistically significant (p = 0.240).

Commuting time between home and workplace was not significantly associated with QWL (p = 0.194); however, those who spend up to 20 minutes reported a higher perception (mean: 81.55 ± 18.39). Similarly, the type of public servant, linked to remuneration, indicated that professionals classified in the SP 6 to 8 group perceive a lower QWL (mean: 79.22 ± 18.29), although without statistically significant differences (p = 0.153).

Academic level was significantly associated with QWL (p = 0.015), indicating that the higher the level of education, the better the perception of quality of work life. Specifically, doctors with doctorates reported the highest levels (103.67 ± 8.02). Similarly, working hours were also significantly associated (p = 0.036), with morning shift physicians perceiving higher QWL (mean: 85.36 ± 17.39) compared to those working evening or night shifts (mean: 59.67 ± 41.35).

Self-perceived health status showed a strong association with QWL ($p < 0.001$), indicating that those who considered their health to be good reported a better perception of QWL (mean: 85.52 ± 13.59), while those who perceived it as poor presented significantly lower values (mean: 49.43 ± 21.37). Although the presence of diagnosed chronic diseases showed no significant relationship with QWL ($p = 0.097$), a relevant association was identified with the presence of psychological ($p = 0.001$) and neurological disorders ($p = 0.021$), which were linked to a lower perception of QWL (mean: 70.81 ± 20.17; mean: 71.95 ± 21.11, respectively).

Regarding socioeconomic status, although no statistically significant relationship was found ($p = 0.548$), it was noted that those who perceived themselves to be at a low economic level reported a lower quality work life (QWL) (mean: 75.5 ± 13.77) compared to those who considered themselves to be at a high level (mean: 84.6 ± 15.03). Concerning financial support at home, no significant association was found either ($p = 0.155$), although an unexpected outcome was observed: participants with the financial backing reported a lower QWL (mean: 77.00 ± 22.12) compared to those who did not receive this support (mean: 82.52 ± 15.06). On the other hand, assistance with domestic activities was associated with a more positive perception of QWL, where those who received this support had an average of 81.31 ± 16.94; however, this association was not statistically significant ($p = 0.690$).

Concerning family composition, having children was significantly linked to QWL ($p = 0.012$), indicating that those with children perceived a higher quality of work life (mean: 83.67 ± 16.06) compared to those without (mean: 75.85 ± 19.14).

Finally, family functioning did not demonstrate a statistically significant relationship with QWL ($p = 0.112$). However, when analysing the means, it was observed that individuals with severe family dysfunction reported a lower QWL (mean: 72.2 ± 12.37), whereas those with moderate (mean: 80.27 ± 14.45) or normal (mean: 80.56 ± 16.06) functioning exhibited a higher perception. Unexpectedly, participants with mild dysfunction reported a better QWL than the other groups (mean: 82.29 ± 19.21).

Variable		Quality of working life					
		N	**%**	$\bar{x}$	**± *DE***	**Test**	***P-valor***
Gender							
	Male	65	48.50	83.49	12.53	2014.500*	0.310
	Female	69	51.50	78.41	20.45		
Age							
	<30 years old	39	29.10	75.74	21.31	4.208**	0.240
	30 - 39 years old	51	38.10	84.63	15.16		
	40 - 49 years old	38	28.40	80.79	15.50		
	≥ 50 years old	6	4.50	82.83	17.99		
Travel time from home to work							
	20 min	106	79.10	81.55	18.39	1246.500*	0.194
	> 20 min	28	20.90	78.32	14.02		
Academic level							

	Third level (undergraduate)	52	38.80	76.38	18.90	10.446**	**0.015**
	Fourth level (master's degree)	40	29.90	83.4	16.78		
	Fourth level (medical specialization)	39	29.10	82.51	15.17		
	Doctorate (PhD)	3	2.20	103.67	8.02		
Work task							
	Direct Patient Care	113	84.30	80.62	17.46	1.121**	0.772
	Administrative	10	7.50	79.3	12.92		
	Management	6	4.50	80.83	13.04		
	Care and administration	5	3.70	89.8	17.89		
Shift types							
	Morning shifts	42	31.30	85.36	17.39	6.649**	**0.036**
	Evening/Night shifts	3	2.20	59.67	41.35		
	Rotating shifts	89	66.40	79.47	16.11		
Category							
	SP 6-8 ($1412 – 1760 USD)	74	55.20	79.22	18.29	1900.500*	0.153
	SP >8 (> $1760 USD)	60	44.80	82.92	16.54		
Perceived health status							
	Good	93	69.40	85.52	13.59	20.868**	**<0.001**
	Fair	34	25.40	74.65	18.31		
	Bad	7	5.20	49.43	21.37		
Presence of diagnosed chronic disease							
	Yes	77	57.50	78.68	18.36	1825.500*	0.097
	No	57	42.50	83.84	16.11		
	Psychological disorders (depression and/or anxiety)						
	Yes	31	23.10	70.81	20.17	993.500*	**0.001**
	No	103	76.90	83.9	15.57		
	Neurological disorders						
	Yes	22	16.40	71.95	21.11	847.500*	**0.021**
	No	112	83.60	82.63	16.32		
	Musculoskeletal disorders						
	Yes	21	15.70	77.00	16.64	941.500*	0.134
	No	113	84.30	81.59	17.71		
	Obesity						
	Yes	18	13.40	83.06	17.68	1000.000*	0.774
	No	116	86.60	80.53	17.6		
	Other						
	Yes	36	26.90	79.33	17.04	1635.500*	0.519
	No	98	73.10	81.44	17.8		

Perception of socioeconomic level							
	Low	4	3.00	75.5	13.77	1.204**	0.548
	Intermediate	115	85.80	80.57	18.01		
	High	15	11.20	84.6	15.03		
Financial support for household maintenance							
	Yes	40	29.90	77	22.12	1.442***	0.155
	No	94	70.10	82.52	15.06		
Children							
	Yes	48	35.80	83.67	16.06	1525.000*	**0.012**
	No	86	64.20	75.85	19.14		
	Children from < 2 years old						
	Yes	17	12.70	86.18	17.3	538.500*	0.603
	No	69	51.50	83.06	15.81		
	Children from 2 to 5 years old						
	Yes	24	17.90	81.63	14.02	641.500*	0.324
	No	62	46.30	84.47	16.82		
	Children from 6 to 12 years old						
	Yes	44	32.80	83.66	16.34	886.500*	0.746
	No	42	31.30	83.69	15.95		
Support in domestic activities							
	Yes	102	76.10	81.31	16.94	1555.500*	0.690
	No	32	23.90	79.47	19.63		
Family functionality							
	Severe dysfunction	10	7.50	72.2	12.37	5.993**	0.112
	Moderate dysfunction	15	11.20	80.27	14.45		
	Mild dysfunction	75	56.00	82.29	19.21		
	Normal	34	25.40	80.56	16.07		

Table 4. Differences in the Perception of the Quality of Working Life

*U de Mann-Whitney; **Kruskal-Wallis; ***Two-sample t-test.

Discussion

Assessing the perception of QWL among personal physicians is crucial for hospital institutions, given the high risk of dissatisfaction, work-related stress, and overload faced by this professional group. Factors such as the demands of high-pressure work, a lack of work-life balance, and almost unconditional dedication to patient care contribute to a negative perception of QWL. Furthermore, poor personal health exacerbates this problem.

Globally, studies on QWL in medical staff remain limited. In the present investigation, the overall perception of QWL was low among nearly half of the physicians (46.3% $\bar{x}$: 80.87 ± 17.56). Similar findings emerged in Nigeria, where 56.1% of physicians reported low QWL (25).

However, other studies have indicated more favourable perceptions. In Turkey, healthcare personnel reported a good overall QWL, with a mean score of 71.07 on the QWL scale (26). In Peru, 54.4% of workers had an average quality of work life, 38.6% reported high, and only 7.0% reported low (27). In Poland, 38.27% of young physicians reported low QWL, which was attributed to poor hospital management (28). Similarly, Saltos Llerena et al. (1) identified a perception of average or regular QoL, potentially influenced by improvements in infrastructure, equipment, and human resource management in second-level hospitals compared to first-level hospitals.

The dimensions that most negatively impact QWL were identified: job integration, job satisfaction, and achieved well-being. These findings are consistent with those reported by Astudillo-Romero et al. (29), who found low scores in the exact dimensions and free time management. Gonzalez y Ledesma (18) highlighted that the main dimension affected in their study was free time management. Storman et al. (28) described the negative perception of QWL in Poland as related to problems with job integration due to poor relationships with superiors (52.27%), lack of job opportunities (49.79%), and poor organizational communication (58.03%). Furthermore, one-third of the surveyed staff reported job dissatisfaction. At the same time, the well-being achieved through work was affected by high levels of stress (93%) and a negative perception of physical (51.85%) and mental (28.68%) health.

Likewise, the academic level significantly influenced the perception of QWL, indicating that physicians with a lower academic degree report a lower QWL. This finding coincides with the study by Van Bezek (30), which identified greater job satisfaction in physicians specialized in anaesthesiology compared to residents and nurse anaesthesiologists. In contrast, Tang et al. (9) reported that physicians with a lower academic level perceive greater job satisfaction, although they have a lower perception of professional capacity, which could be related to the workload and expectations according to the level of training.

Another determining factor was the relationship between QWL and work schedule. Physicians working evening and night shifts reported lower perceptions of QWL compared to those working morning shifts. Although previous studies have not directly addressed this relationship, research by Goetz et al. (24) and Oh et al. (25) has shown that long work hours reduce job satisfaction by limiting free time.

Self-perception of health showed a statistically significant relationship with QWL, indicating that those who reported better health had higher QWL. Sultan (33) describes that in Pakistan, occupational diseases affect QWL, particularly in the physical and mental dimensions. In this research, the analysis of chronic diseases revealed a significant association with mental health and neurological disorders, a finding consistent with the study by Moreira (34), in which 42.7% of physicians were diagnosed with anxiety and 30.3% with depression, conditions that negatively impact QWL, especially in the young population. Other diseases, such as hypertension (17.4%), obesity (17.1%), and thyroid disorders (10.5%), were also reported as factors contributing to lower QWL.

Finally, it was shown that the presence of children is associated with a better perception of QWL. Nasetta, (26) points out that having children and a stable relationship correlates with greater QWL by providing stability and motivation for professional development.

Conclusions

The quality of work life of healthcare personnel is determined by factors such as academic level, work schedule, the presence of psychological and neurological disorders, self-perceived health status, and parenthood. The conditions that most negatively affect quality of work life include a lower academic level, working evening or night shifts, and the presence of psychological disorders such as depression and anxiety.

Medical personnel have a low perception of their quality of work life, with the most affected dimensions being integration into the workplace, job satisfaction, and well-being derived from professional practice. This suggests difficulties adapting to the work environment and a limited perception of recognition and reward for their performance. It is also linked to dissatisfaction with key aspects such as working conditions, interpersonal dynamics, autonomy in professional practice, and perceptions of achievement and development.

These findings highlight the need to implement effective strategies to improve medical personnel's working and health conditions. Optimizing the work environment, strengthening psychological support, and adjusting work schedules could significantly contribute to a better perception of quality of work life, which, in turn, would positively impact the quality of healthcare and the efficiency of the healthcare system.

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