

The psychosocial risks, suffering and quality of work life among health workers

المخاطر النفسية الاجتماعية والمعاناة وجودة الحياة في العمل لدى العاملين في مجال الصحة

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Received:22/01/2024

Accepted:08/09/2024

Abstract:

This article explores the psychological risks (PSRs), suffering, and quality of work life of health workers. PSRs refer to any threats to psychological, physical, and social health in the workplace, particularly in the healthcare sector. These threats are caused by the pressures of constant emotional contact with patients, resulting in suffering in the workplace. This suffering affects mental functioning and is also influenced by the organization of work in all professional and relational aspects. Understanding the issues surrounding PSRs and the suffering of health workers is crucial and must consider factors such as stress, burnout, and violence. In conclusion, addressing PSRs and the suffering of health workers requires a shift in perspective towards viewing work as a source of well-being, satisfaction, and accomplishment rather than suffering and illness. This is where the concept of quality of work life becomes essential.

Keywords: Burnout; Harassment; Stress; Quality of Work life; Violence.

ملخص:

يستكشف هذا المقال المخاطر النفس اجتماعية (PSRs) والمعاناة وجودة حياة العمل للعاملين في مجال الصحة. تشير المخاطر النفس اجتماعية (PSRs) إلى أي تهديدات للصحة النفسية والجسدية والاجتماعية في مكان العمل، بشكل خاص في قطاع الرعاية الصحية. تتسبب هذه التهديدات في ضغوطات كنتيجة للاتصالات العاطفية المستمرة مع المرضى، مما يؤدي إلى المعاناة في مكان العمل. تؤثر هذه المعاناة على الوظائف العقلية وتتأثر أيضًا بتنظيم العمل في جميع الجوانب المهنية والعلائقية. من الضروري فهم المشكلات المحيطة بالمخاطر النفس اجتماعية (PSRs) ومعاناة العاملين في مجال الصحة ويجب أخذ عوامل مثل التوتر والاحتراق المهني والعنف في الاعتبار. في الختام، تتطلب معالجة المخاطر النفس اجتماعية (PSRs) ومعاناة العاملين في مجال الصحة تغييرًا في وجهة النظر، حيث ينبغي أن يُنظر إلى العمل كمصدر للرفاهية والرضا والإنجاز بدلاً من المعاناة والمرض. هنا حيث يصبح مفهوم جودة الحياة في العمل أساسيًا.

الكلمات المفتاحية: احتراق نفسي؛ تحرش؛ إجهاد؛ جودة الحياة؛ عنف.

1. Introduction

Work is considered essential to human beings because it can ensure both moral well-being and material comfort. As such, work is an indispensable resource for ensuring a dignified lifestyle and serves as a positive and significant agent in society. Jahoda argues that work offers both direct and indirect benefits beyond merely providing a means of subsistence.

Work also has an undeniable impact on health, either as a source of satisfaction and well-being or as a cause of deterioration in the physical and mental health of the worker. According to Légeron (2018), work can be a source of suffering; however, it is important to remember that it also protects both physical and psychological health. Additionally, individuals without work are more susceptible to developing work-related pathologies, such as depression and suicide.

In this context, Krauze et al. argue that it is not the work itself that is to blame, but rather the way it is organized and managed. Légeron (2018) states, whereas Debout et al. assert that work can be a factor for balance in the development and structure of health. However, its negative effects emerge when it becomes a source of disqualification, conflict, suffering, or exposure to risky or dangerous situations (Debout et al., 2009). Lhuillier and Litim (2009) argue that the focus on health damage caused by work tends to overshadow work as a health factor.

It is evident that work and mental health are interconnected and mutually influence each other. The World Health Organization defines mental health as a state of well-being that enables individuals to achieve their full potential, cope with normal life challenges, work productively, and contribute to their community (Guelfi, 2018).

Furthermore, Djeriri and Chamoux (2012) consider work and health from an interactionist perspective, assuming that health at work results from the individual's relationship with their work. This relationship is more or less facilitated or compromised by the way the tensions generated by new modes of organization are managed. It is the responsibility of the managerial staff of the work organization to manage tensions and conflicts to preserve the health of its workers.

Although the question of the relationship between work and mental health is relatively old, it has come to the fore again today because men and women

no longer accept suffering at work. The demand for wellbeing has therefore grown significantly. (Légeron, 2018).

The concept of well-being is broader than that of health, and well-being at work is becoming a central issue in the professional sphere. It highlights the significant changes in the workplace, where workers no longer accept suffering and demand the right to well-being.

The above elements aim to answer the following questions:

What are the PSRs at work faced by health workers? How do these PSRs impact health and the organization of work? How to engage in a process of prevention of PSRs in the workplace?

In this article, we will first examine the issue of suffering at work and the main psychosocial risks faced by health workers. We will then highlight the negative impact of psychosocial risks at work on health workers, particularly in terms of stress, burnout, violence and harassment. Finally, the concept of quality of work life will be developed as a means of promoting well-being and health at work.

Objectives of the article:

Our research questions aim to address the following elements of analysis:

- The issue of well-being and suffering in the workplace of health workers;
- Psychosocial risks (PSRs) at work experienced by health workers;
- The impact of PSRs at work on health workers;
- The need to promote a good quality of life for health workers in the workplace.

2. Article terms:

Health workers:

In this article, the term "health workers" refers to doctors and nurses in both the public and private sectors who are responsible for helping patients recover from or manage their illnesses.

Suffering at work: This refers to mental suffering linked to the work itself or to the work context, which has negative repercussions on the psychological, physical, and social aspects of the person.

Quality of Work Life: This involves providing favorable working conditions at both individual and organizational levels to promote self-accomplishment, job satisfaction, and performance in the workplace.

Psychosocial risks (PSRs): Psychosocial risks correspond to work situations where the following exist:

Stress: An imbalance between a health worker's perception of the constraints of their work environment and their perception of their own resources to cope with them.

Internal violence at the workplace: Includes moral or sexual harassment, aggravated conflicts between colleagues, or conflicts between teams.

External violence: Perpetrated against health workers by people external to the medical environment (insults, threats, assaults, etc.).

These risks can be induced by the medical activity itself or generated by the organization and working relationships.³ Dimensions of Mental Health in the Workplace

Psychological health in the workplace has two essential dimensions, according to Saunder (2016):

The first dimension is negative and focuses on repairing PSRs factors.

The second dimension is positive and focuses on promoting well-being and happiness in the workplace, through a preventive approach.

When discussing mental or psychological health in the workplace, it is important to consider the economic impact, due to regular work stoppages (sometimes of long duration), hospitalizations and intensive drug treatments. Therefore, it is necessary to evaluate the well-being and ill-being at the workplace, by analyzing the three components of work, as outlined in Karasek's model:

- Psychological demand in the workplace: refers to the evaluation of the worker's performance in assigned tasks, including speed, contradictory injunctions, fragmented tasks, and dependence on others.
- autonomy or decision latitude at the workplace: deals with decision-making, use of skills, development of knowledge, competences and creativity, etc.

- Social support in the workplace : examines help and support at work. (Djeriri & Chamoux, 2012).

3. Suffering at work among health workers

As previously mentioned, work is considered an important factor in mental health because it enables individuals to construct their "self" (Delieutraz, 2018, p. 15). Work humanizes, socializes, and can even promote healing through occupational therapy. However, professional activity can also generate mental suffering, particularly in professions requiring frequent contact with people.

In the medical field, work-related suffering is inherent due to the constant exposure to complex and challenging aspects of human life such as illness, death, and mental health issues. This daily confrontation can lead to gradual exhaustion, resulting in a reduction of defense mechanisms and less resistance (Delieutraz, 2018). Exhaustion is the physical and bodily response to prolonged immersion, undermining the health worker's ability to cope with a job that drains their resources. Unable to release the tensions accumulated over the years, the result is psychological and sometimes even physical deterioration.

Several types of stress in the workplace are thought to explain health workers' burnout: time constraints, work rhythm, physical constraints, relations with the public, and mental and emotional load. Overwork can also increase the risk of medical errors.

Health workers are at high risk of experiencing mental suffering and disorders, ranging from sleep disorders and severe fatigue to anxiety, depression, and even suicidal behavior. According to Hardy (2018), over half of physicians exhibit symptoms of burnout and face a higher risk of anxiety disorders, depression, and suicide compared to most other professions. This work-related suffering is associated with psychosocial risk factors (PRFs) that can lead to physical or psychological distress among health workers.

4. What is a psychosocial risk (PSR)?

According to Bellego, PSRs have been linked to the organization of work since the 2000s due to social crises in companies (Bellego, 2012). The Collège d'Expertise defines PSRs as “risks to mental, physical, and social health caused by employment conditions and organizational and relational factors likely to interact with mental functioning” (Bellego, 2012, p. 51).

PSRs are classified into two dimensions: stress, and harassment, violence, and incivility (Saunder, 2016).

On the other hand, some authors such as Miossec & Clot (2011) and Valléry & Leduc (2012) argue that PSRs are situated at the junction of the psychological, social, and organizational domains. PSRs refer to occupational hazards that compromise the physical and mental well-being of employees (Sissler, 2014). In summary, PSRs are occupational risks associated with working conditions that threaten or negatively affect a person's health in all aspects.

5. Classification of PSRs at the workplace

In his work, Ribéreau-Gayon distinguishes three types of PSRs (Bellego, 2012):

- Material and immaterial PSRs: Material risks are quantifiable and linked to the use of machinery or raw materials (e.g., radioactivity), which can be regulated. In contrast, immaterial risks cannot be regulated and are linked to pathogenic work organization.
- PSRs related to individuals: These include moral or sexual harassment, as well as violence by employees or third parties.
- PSRs related to the organization: These are due to the pathogenic effects of the organization, such as excessive workload, lack of autonomy, and the blurring of boundaries between private and professional life.

In 2011, Gollac and Bodier grouped PSRs into six main categories (Hardy, 2018):

- Intensity of work and working time: Includes unrealistic or unclear objectives, contradictory instructions, and unpredictable working hours.
- Emotional demands: The need to control and manage one's emotions in any situation, requiring total self-control.
- Lack of autonomy: The inability to play an active role in one's work, participate in decisions directly affecting one's activity, or develop one's skills.
- Poor social relations in the workplace: Includes relations with colleagues or the hierarchy, as well as pathologies in social relations (e.g., moral harassment).

- Value conflicts (ethical suffering): Conflicts caused by discrepancies between job demands and the professional, social, or personal values of the employee.
- Job insecurity: Includes both socio-economic insecurity (fear of losing one's job, precarious working contracts) and the risk of uncontrolled changes in tasks and working conditions.

To summarize, PSRs are risk factors related to working conditions that can take various forms, such as stress, burnout, moral harassment, or even violence at work, and they affect the health of the employee in the short and long term.

6. PSRs among health workers

6.1. Stress and Burnout

6.1.1. Stress

Légeron explains that the notion of stress first raised questions about the threat to mental health posed by work (2018). Stress is not a pathology but rather an inherent and sometimes necessary part of life and work. The concept of stress, developed by Hans Seyle, refers to a person's natural physiological reaction to aggression, threat, or unexpected situations. De Clercq and Dubois (2001) state that this reaction impacts the somatic, psychic, and motor spheres simultaneously. Stress is highly reactive and dissipates with the disappearance of the stressor, serving as a short-lived response to help the organism adapt to stress.

Wainwright and Calnan (2002) propose two explanatory models for work-related stress (Buscatto, 2008):

Stress can be caused by difficult conditions in the workplace, leading to fatigue and wear.

It can also be caused by an individual's personality and low resistance.

Moisson-Duthoit (2016) distinguishes between two fundamental approaches to stress: Segriest's transactional approach and Karasek's interactionist viewpoint. Segriest's model emphasizes the individual's perception of their environment as the main factor influencing their reaction to stress. Karasek's model suggests that stress is caused by a lack of decision-

making opportunities and high levels of constraint. Both models provide insight into the causes of stress and can be useful in understanding and managing it.

Maslach explains that stress may arise from an individual's inability to respond to what they consider to be an excessive demand due to a lack of resources, which can be detrimental to their well-being (Delaye, Boudrandi, 2010).

In short, stress is a precursor to burnout, but stress can occur without necessarily leading to burnout.

6.1.2 – Burnout

Maslach and Jackson (1981) defined burnout as a syndrome characterized by three main aspects:

- It affects individuals who are exposed to emotional overload due to their professional activities, which are typically focused on meeting the needs of others (such as social workers, healthcare providers, educators, etc.).
- The clinical syndrome of burnout manifests primarily through emotional exhaustion, which develops from chronic exposure to stress.
- It encompasses three dimensions:
 - Emotional exhaustion: Feelings of being emotionally drained and overwhelmed by one's work.
 - Depersonalization: Developing negative, cynical attitudes and feelings towards clients, patients, or students.
 - Personal accomplishment: A decrease in feelings of competence and successful achievement in one's work.

Maslach and Jackson's framework highlights how burnout is a complex syndrome affecting professionals in helping professions, impacting both personal well-being and job performance.

According to Rulkin, burnout is the consequence of prolonged stress and signifies the depletion of physical, mental, and emotional capacities. It develops gradually, though it may appear sudden (Delieutraz, 2018). The onset of burnout is a protracted process that can span several years due to sustained workplace stress. It involves a gradual depletion and erosion of

personal resources. This erosion can lead to feelings of failure, loss of self-esteem, and ultimately, depression (Roussel, 2005).

It's important to note that burnout is classified not as an illness, but rather as a collection of symptoms. The recognition of burnout as an occupational disease remains a topic of ongoing international debate.

Additionally, Marie, Mazeran-Lumley, Faruch, Pinel, and Fernandez (2004) conducted prevalence studies among caregivers, medico-social workers, and socio-educational workers, revealing higher rates of burnout compared to other professions. Studies in England have highlighted concerning statistics regarding the mental health of medical professionals. Specifically, 2% exhibit signs of burnout, 40% experience emotional exhaustion, over 15% show signs of depersonalization, and 25% report persistent job dissatisfaction.

These findings indicate elevated levels of burnout, stress, depression, and even suicide. In Algeria, research by Benferhat Amirouche in 2009 focused on SAMU (Emergency Medical Service) physicians in Algiers, Blida, and Médéa, showing high levels of all three dimensions of the burnout syndrome among physicians in these regions (Benferhat, 2013, p. 140). Similarly, a study involving 44 night nurses at the Multi-Service Clinic in Souk Naamane, Algeria, indicated a high prevalence of burnout (Benferdi & Feddal, 2023). Studies in the United States also consistently show that physicians are more susceptible to burnout compared to professionals in other fields (Dzau, Kirch, and Nasca, 2018) (Hardy, 2018).

Another study highlights the detrimental impact of burnout on health. The ESTEM survey, conducted anonymously online between September and October 2017, involved 1,436 senior physicians and interns at Paris-Sud University Hospitals (AP-HP). Results showed that 88.5% of the 523 respondents considered their work to be a significant source of stress, mental suffering, or burnout (Hardy, 2018). The survey also revealed that 49.5% of doctors reported experiencing personal burnout, and 10.7% had a confirmed depressive syndrome. Notably, the study found that nearly all physicians who were depressed also reported high levels of burnout. Additionally, the suicide rate among physicians is higher compared to the general population (Hardy, 2018, p. 50).

An Austrian study published in 2016 surveyed 5,897 physicians, revealing that 10.3% experienced a depressive syndrome and 50.7% reported burnout (Hardy, 2018). According to Grebot (2008), burnout affects a significant percentage of caregivers, hospital ward staff, and hospital nurses, with rates of 25%, 40%, and 48%, respectively. These high rates are attributed to the excessive demands for dedication and self-sacrifice imposed by institutions, despite challenging working conditions.

Grebot suggests that these issues must be addressed to improve the well-being of healthcare workers. Caregivers often report feeling frustrated, tired, and undervalued, while healthcare professionals may experience a loss of meaning in their work. Another Austrian study, published in 2016 and involving 5,897 physicians, found that 10.3% experienced a depressive syndrome and 50.7% reported burnout (Hardy, 201).

Grebot also notes that burnout affects 25% of healthcare workers, 40% of hospital staff, and 48% of hospital nursing staff. These high rates are attributed to institutions demanding increasing dedication and self-sacrifice, despite challenging working conditions. Consequently, healthcare workers often feel frustrated, tired, and undervalued, exacerbating their suffering due to a loss of meaning in their work. (Grebot, 2008).

According to Delaye and Boudrandi (2010), in Japan, burnout equivalent to Karoshi, or "Death by Work," is reported. Karoshi leads to fatal outcomes such as death by exhaustion, and annually, approximately 10,000 people die at work in Japan.

6.1.3 - Sources of burnout among health workers

Lemaire and Wallace (2017) identify three sources of burnout among health workers: cultural, individual, and organizational (Hardy, 2018):

- Cultural factors: A particular medical culture denies physicians the possibility of being vulnerable and tends to ignore their distress;
- Individual factors: certain personality traits, such as perfectionism or conscientiousness, as well as the use of certain stress adaptation strategies represent risk factors for burnout.
- Professional factors: workload plays a predominant role in the genesis of burnout.

Courtial and Huteau conducted a study on burnout among psychiatric nurses revealed that some nurses attributed the origin of burnout to technical factors such as working conditions, choice of workplace, type of training, tasks in several departments, their place in the team, and the many medical rules ...The other group of nurses believe that burnout is linked to themselves.

For Courtial and Hurteau, the results obtained from this study show that, for all nurses, burnout occurs as a result of the convergence of the following factors: lack of time, workload, difficulty of overall care, demotivation linked to pressure and relations with hierarchy (2005). As a result, all the nurses in this study consider that the burnout they suffer stems from working conditions that exceed their capacity to adapt.

West, Dyrbye, and Shanafelt's (2018) studies on risk factors for burnout among caregivers found that working an additional hour per week increases the risk of burnout by 3%. Similarly, each additional weekly night or weekend on-call duty increases this risk by 3% to 9%, and each additional weekly hour worked at home increases it by 2% (Hardy, 2018). On the other hand, it is important to highlight the role of work organizations and management styles as a source of burnout (Hardy, 2018, p. 52).

6. 2.- Violence and Harassment in the Workplace

6. 2. 1. - Violence in Healthcare Establishments

The World Health Organization (WHO) defines violence as the intentional use of physical force or threats against individuals, groups, or communities, resulting in trauma, psychological harm, developmental difficulties, or death (Gourevitch et al., 2018).

Regarding violence in the workplace, Saunder (2016) defines it as any situation where one or more employees are assaulted. This can take the form of disrespect, nuisance, destruction, incivility, or physical aggression, and can be verbal, behavioral, gender-based, or physical. The range of workplace violence is broad, encompassing everything from disrespect to physical aggression.

The health sector is not immune to the risk of tensions or oppositions arising, which can lead to aggressive or even violent behavior. According to Molinier, the aggressiveness of certain men of power towards their

subordinates - and in particular the crisis manifested by surgeons towards their nurses - is an attitude of sadism that allows them to vent their own tensions. (Molinier & Flottes, 2012).

Even if violence in the workplace concerns all professional environments, violence in the medical environment seems to predominate, and health workers seem to be more exposed to verbal, physical or psychological violence. Violence and aggression can also emerge in a context of emotional disturbance caused by illness or anxiety, and can originate from patients, their families, or the health workers themselves.

6. 2. 2.- Moral Harassment

Harassment is present in the medical profession. It can occur at the individual level through the abuse of power by a department head or administrator, or at the institutional level. According to Hirigoyen, moral harassment is a complex process with origins linked to various psychological, sociological, and managerial factors that interact and reinforce each other (Hirigoyen, 2016, p. 53). Hirigoyen explains that violence and harassment in the workplace generally stem from a combination of the desire for power and perversity (1998). The author clarifies that workplace harassment refers to any abusive conduct in the form of behavior, words, deeds, gestures, or writings that could undermine a person's personality, dignity, or physical or psychological integrity, jeopardize their job, or degrade the working environment (Hirigoyen, 1998).

Harassment is a form of moral destruction that has always existed. In times of full employment, individuals who were victims of harassment could cope by leaving their jobs. However, in today's challenging job market, victims of harassment often feel compelled to hold onto their positions, which can have a detrimental impact on their moral and physical well-being.

Workplace harassment can be extremely harmful to its victims, as it erodes their dignity and poses a threat to both their physical and psychological health. Furthermore, harassment in the workplace creates a toxic environment that diminishes productivity by increasing absenteeism due to the harm inflicted on employees' health.

According to Quine (1999), workplace harassment encompasses four dimensions:

- Hostile acts;
- Persistent acts in terms of frequency and duration;
- Harmful consequences for the target person;
- A power imbalance between the harasser and the harassed (Carroll, Foucher, & Gosselin, 2012).

7. The impact of PSRs in the workplace on the health of healthcare workers

PSRs can negatively affect the mental and physical health of healthcare workers. The list of symptoms resulting from exposure to PSRs is not exhaustive, and includes both psychological and physical consequences.

7.1. -Mental and somatic consequences

The mental effects observed include reduced cognitive performance, especially in attention and decision-making, as well as fatigue, stress, depression, and anxiety. In addition, various somatic reactions are noted, including musculoskeletal disorders such as muscle tension and back pain, and endocrine disorders like diabetes (Callahan, 2018).

According to Auger (2018), chronic stress symptoms can include physical pain, sleep and eating disorders, shortness of breath, feelings of oppression, depression, anxiety disorders that may lead to suicidal thoughts or actions, excessive use of psychoactive drugs like anxiolytics, hypnotics, and antidepressants, addictive behavior, immune damage, and cardiovascular diseases.

7.2.- Internal effects on personal and collective work

These effects include a lower quality and quantity of work, decreased motivation and commitment, and behavioral deviations such as theft and sabotage.

7.3.- Internal consequences on the functioning of the organization

Frequent unjustified absences, intention to leave work, or actual departure, as well as damage to the organization's image, are all potential consequences (Brillet, Sauviat, & Soufflet, 2017).

8. Preventing PSRs in workspace

According to Hardy (2018), the development of policies for preventing PSRs involves three levels:

- Primary prevention actions, which aim to reduce risk factors.
- Secondary prevention, which focuses on early detection and management of disorders caused by PSRs.
- Tertiary prevention, which involves managing existing disorders and preventing recurrences.

9. PSRs and Quality of Work life in workspace

Shedding light on the impact of psychosocial risks (PSRs) on health is essential. In addition to addressing the issue of suffering in the workplace, PSRs among healthcare workers indicate managerial failures and indicate a toxic organizational culture that undermines the effectiveness of this professional setting. Therefore, discussing Quality of Work Life (QWL) requires us to shift from viewing work as dehumanizing, with psychosocial risks and suffering, to considering it from a positive perspective focusing on well-being and satisfaction. Work should be seen as a domain of well-being, rather than solely a source of risk and suffering.

The concept of well-being encompasses more than just physical health. The issue of well-being in the workplace has become crucial as it highlights significant changes in the nature of work. Workers are increasingly unwilling to endure workplace distress and are asserting their right to well-being.

According to WHO (2005) in a conference about mental health, it is stated that the quality of life relies on mental health and well-being, as they give purpose to our lives and empower us to be creative and productive members of society. Mental health plays a critical role in fostering peace, social cohesion, productivity, and stability. Furthermore, a good quality of life contributes to improving social and economic aspects. Therefore, enhancing mental well-being is imperative. As a result, adopting a well-being-at-work approach could help maintain good physical and mental health, encourage professional growth, and reduce workplace stress, burnout, and violence.

The notion of Quality of Work Life is intertwined with that of health in the workplace. The International Labour Office and the WHO outline that health at work should aim to:

- The promotion and maintenance of a high level of physical, mental, and social well-being for workers in all occupations;
- The prevention of damage to health caused by working conditions;
- Providing protection in the workplace against all agents harmful to health;
- Matching the job to the worker's abilities (Brillet, Sauviat, & Soufflet, 2017).

A study on the Quality of Work Life in local health centers in Tizi Ouzou was conducted on a sample of 60 nurses, revealing a decline in their Quality of Work Life (Boukezzoula & Elahcene, 2022). As Kostulski (2010) points out, psychological and physical well-being at work is not determined by the quantity of work but by the ability to deliver quality work, introducing a new perspective on the issue.

These findings suggest the need for a systemic approach to work that includes:

- Dynamic and organized interaction among all elements;
- A clear purpose;
- Engagement with both subjective and objective dimensions (related to both the individual and the organization).

In summary, Quality of Work Life encompasses favorable working conditions that have positive impacts on both individuals and organizations, ultimately leading to job satisfaction.

10. Conclusion

The reflective and analytical elements developed throughout this article lead to the conclusion that the research questions posed at the beginning can be answered as follows: Psychosocial risks (PSRs) are threats to the mental, physical, and social health of health workers that result from stress, violence, and inappropriate or conflicting working conditions. These risks may be

caused by hazardous exposure, pathological interactions, or excessive workloads. Work-related stress occurs when conditions at work diminish the health worker's ability to cope, leading to various physical and psychological disorders such as depression, anxiety, concentration and sleep issues. Additionally, PSRs also impact patients, as a stressed or depressed physician may struggle to make accurate diagnoses or provide proper care.

However, PSRs and workplace suffering are not inevitable for health workers, and certain preventive measures can be implemented such as:

Provide stress management training for medical staff;

Evaluate objectively management failures at the medical or administrative level;

Resolve workplace conflicts through dialogue and positive communication;

Avoid overloading health workers;

And establish a support system for health workers in distress.

These measures all contribute to promoting well-being and a satisfactory quality of work life.

In conclusion, quality of life and quality of work are closely interconnected. Quality of work is a psychological factor that influences good health and supports professional growth, enabling individuals to utilize their intelligence, creativity, and sense of responsibility. In return, quality of work life enhances well-being and job satisfaction, leading to better quality work and self-appreciation by oneself and others.

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