

WELL-BEING AMONG ANESTHESIA PROVIDERS: RESULTS FROM A NATIONAL SURVEY

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ABSTRACT

Introduction: Anesthesiology is a demanding medical specialty that requires intense focus, long working hours, and frequent exposure to high-stress situations. These factors often lead to significant occupational stress. Supporting the well-being of anesthesiologists is essential for maintaining patient safety and a stable healthcare workforce.

Methods: We conducted a survey among anesthesiology residents and specialists in North Macedonia. Standardized tools were used, including the Safety Attitudes Questionnaire (SAQ), WHO-5 Well-Being Index, and custom questions related to workplace culture, mental health, and teamwork. Data were collected anonymously via Google Forms and analyzed with SPSS v29.0, focusing on work conditions, psychological well-being, and burnout levels.

Results: A total of 100 participants participated—60% residents and 40% specialists. Residents reported significantly higher stress and burnout, along with lower perceived support from institutions and weaker team dynamics ($p < 0.05$). Specialists noted better job satisfaction and stronger organizational backing ($p < 0.05$). Both groups highlighted a lack of mental health support and weak safety culture, particularly in under-resourced settings; however, these differences were not statistically significant ($p > 0.05$). Overall, resource limitations were widely recognized as key contributors to workplace challenges in middle-income countries ($p < 0.05$).

Conclusion: Anesthesiology residents face higher levels of stress and lower job satisfaction compared to specialists, with resource constraints worsening these disparities. To address these issues, targeted interventions are needed, including mental health support services, mentoring programs, stress management training, and policies that promote a positive work environment and psychological safety.

Keywords: anesthesiology, burnout, mental health, occupational stress, wellbeing

INTRODUCTION

In an ever-changing landscape of the workforce in medicine, one medical specialty has gained recognition as being a fundamental pillar in every healthcare system: anesthesiology. Anesthesiologists were a pivotal workforce during the Covid-19 pandemic. During disasters, such as pandemics or

other types of natural or man-made disasters, anesthesiologists have the required medical skills, such as airway management, hypovolemic shock management, cardiopulmonary resuscitation, triage, etc.—that make them the most sought-after doctors to manage the disaster victims. In times

of peace and prosperity, anesthesiologists provide safe anesthesia for patients of all age groups, from neonates to geriatric patients, which requires a large quantum of medical knowledge gained through rigorous training during specialization and continuous medical education. This variety of medical aspects that are part of everyday work requires certain mental sharpness and stamina from anesthesiologists [1-3].

The well-being of anesthesiologists in relation to their work has been receiving increasing attention due to its enormous impact on both professional performance and patient outcomes. There is a widespread consensus that anesthesiology is one of the most demanding medical disciplines. This specialty is characterized by a high cognitive load, unpredictable work hours, and a significant emotional strain [1, 2]. Burnout, job dissatisfaction, and even the intention to leave the profession are all potential outcomes of prolonged exposure to stressors that are often associated with a particular expertise [3, 4].

Burnout and psychological distress are substantially more prevalent among anesthesiology workers, according to previous research [2, 5]. This is because the combination of high responsibility, lengthy shifts, and short recovery time significantly increases the likelihood of experiencing burnout.

Having a supportive organizational culture, effective leadership, a workload that is reasonable, chances for professional development, and positive interpersonal interactions are all critical components that can help reduce stress and enhance well-being [5, 6]. On the other hand, poor communication, a lack of institutional support, and an excessive administrative burden contribute to unhappiness and attrition from the profession [4-6]. During the course of their work as front-line physicians involved in airway management, critical care, and perioperative medicine, anesthesiologists were subjected to demands that had never been seen before, which further emphasized the need to implement systemic interventions that were designed to preserve their well-being [7].

Although there is a greater awareness of these challenges, there is still a dearth of comprehensive data that investigates the complex factors that contribute to the quality of life that is associated with employment among anesthesiologists. This is especially true when considering the situation from the perspective of both those who are trained in the field and those who are special-

ists. Additionally, anesthesiologists working in low- and middle-income countries (LMICs) may encounter even higher obstacles due to inadequate resources, workforce shortages, and poor institutional support, further compounding occupational stress and burnout [8].

In response to these concerns, a comprehensive survey was carried out among residents and specialists in North Macedonia to analyze critical aspects of work satisfaction, mental health, and circumstances in the workplace. Through the identification of modifiable characteristics within the work environment, the purpose of this study is to provide useful insights that might inform strategies for improving the professional life of anesthesiologists, thereby increasing both the health of providers and the safety of patients.

MATERIALS AND METHODS

An evaluation that was cross-sectional, anonymous, and based on questionnaires was carried out. The survey was produced with Google Forms, and it was meant to allow for quick and confidential participation while maintaining confidentiality. To ensure the confidentiality of the responses, they were automatically gathered and saved in a Google Sheets database that was encrypted. Only the principal investigators had access to this database.

Survey Structure and Content

There was a total of 28 core questions included in the questionnaire, which was organized into nine sections and included both standardized and custom-designed items. Both types of questions were included. It included both closed-ended questions and questions based on a Likert scale, and it provided standardized answer choices to ensure that the responses of different respondents could be compared. According to the nature of each issue, the majority of Likert scales were five-point scales that ranged from "Strongly Disagree" to "Strongly Agree" or their logical equivalents. In addition, open-ended questions were included to collect the additional comments and suggestions made by the participants. Not only did the survey have verified components from internationally established instruments such as the Safety Attitudes Questionnaire (SAQ), WHO-5 Well-Being Index, and Copenhagen Psychosocial

Questionnaire (COPSOQ), but it also included custom-developed questions that were customized to local healthcare settings. These additions enhanced the validity of the data as well as the contextual relevance of the gathered information. Table 1 contains the presentation of the survey's structure and content.

Distribution and Participant Recruitment

Email, institutional communication platforms, and professional forums were the means by which the link to the survey was communicated electronically across the whole national network of anesthesiologists. Participants included both residents who were in the process of becoming clinical anesthesiologists and specialists who were already working in the field. At the time that the survey was being completed, the criteria for inclusion included participation in clinical anesthetic practice as well as current employment as an anesthesiology

resident or specialist. Without exception, participation was fully voluntary and anonymous. A rigorous adherence to confidentiality was maintained throughout the whole process of data collection, and no personally identifying information was gathered about the participants. The Institutional Review Board conducted a review and gave its approval to both the study protocol and the survey instrument before they were sent out to participants. Respect for individuality, privacy, and voluntary involvement without any kind of compulsion were among the ethical standards that were adhered to during the course of the research.

Sample Size Determination and Power Analysis

The sample size was established based on the study's principal aim: to identify substantial disparities in stress, burnout, and perceived institutional support between anesthesiology residents and specialists operating in resource-limited

Table 1. *Survey Structure and Content*

Section	Focus Area	Number of Questions	Example
Demographics	Profession, years of experience, department	5	Resident, Specialist
Workplace Culture	Respect, inclusivity, leadership support	4	Hospital fosters respect (Likert 1–5)
Interpersonal Relationships	Teamwork, conflict resolution, colleague support	3	Satisfaction with teamwork
Work Circumstances & Facilities	Equipment, workload, safety protocols	4	Adequacy of equipment
Mental Health & Wellbeing	Work-related stress, coping mechanisms	5	Work-life balance, peer support
Management Support	Access to mental health resources, burnout awareness	4	Hospital provides counseling
Workplace Safety Culture	Error reporting, resource limitations	2	Encouragement to report concerns
Mental Health Screening	Emotional wellbeing and burnout	2	WHO-5
Management Support (Additional)	Leadership interest, psychological support availability	2	Supervisory support

Legend: The questionnaire includes validated components from four internationally recognized instruments: the Safety Attitudes Questionnaire (SAQ), the WHO-5 Well-Being Index, and the Copenhagen Psychosocial Questionnaire (COPSOQ). Permission to use these instruments was obtained as follows: The WHO-5 is freely available for non-commercial academic use; the SAQ was used under educational research terms; and the COPSOQ was accessed under the terms of its Creative Commons Attribution License (CC BY-SA 4.0). Custom-designed items were created by the authors to reflect the specific clinical and cultural context of anesthesiology practice in North Macedonia.

settings. A priori power analysis was conducted utilizing G*Power 3.1.9.7, focusing on a two-tailed Mann-Whitney U test (the nonparametric alternative to the t-test for independent samples), presuming a medium effect size (Cohen's $d = 0.5$), a significance threshold (α) of 0.05, and a statistical power ($1-\beta$) of 0.80. The computation revealed that at least 64 participants (32 each group) were necessary to detect significant differences between groups. To improve generalizability and address probable non-responses, we enlisted 100 participants (60 residents and 40 specialists). This surpassed the minimum sample size criterion and facilitated subgroup comparisons. Statistical analyses were conducted using SPSS v29.0, employing suitable nonparametric tests (Mann-Whitney U, chi-square, Fisher's exact) according to data distribution. These measures guaranteed enough statistical power and dependability in achieving the study's objectives.

Statistical Analysis

For the purpose of data analysis, IBM SPSS Statistics for Windows, Version 29.0, was utilized. In order to provide a concise summary of demographic factors, workplace conditions, interpersonal interactions, mental health indicators, and views of organizational support, descriptive statistics were utilized. Examples of categorical variables were presented in the form of percentages and frequencies. The non-normal distribution was evaluated visually and through the Shapiro-Wilk test, and as a result, medians and interquartile ranges were provided for both ordinal and continuous data. For categorical variables, the chi-square test or Fisher's exact test was utilized, and for ordinal or continuous nonparametric data, the Mann-Whitney U test was utilized. Group comparisons were carried out using these statistical methods. A p-value with two tails that was less than 0.05 was regarded as statistically significant.

RESULTS

The survey was completed by a total of one hundred specialists in the field of anesthesiology; sixty percent of whom were residents and forty percent were specialists. Chart 1 provides a summary of the distribution of participants according to their occupation, number of

years of residency, and number of years of professional experience. ICU/Critical Care (20%), Pediatric Anesthesia (10%), and other specialist units (23%), followed by the General Operation Room (47%), were the most common places of employment for the majority of the participants.

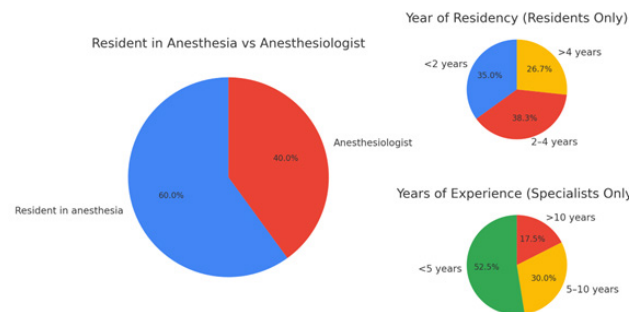


Chart 1. *Patients demographic overview*

In general, the assessments of workplace culture were positive, with high scores for respect, inclusivity, and the approachability of leadership personalities. However, the ranking for mission alignment was significantly lower than the other categories. Chart 2 provides a graphical representation of the ratings given to the culture of the company. There were no statistically significant differences identified between the ratings that residents and specialists reported for the workplace culture (Mann-Whitney U test, $p > 0.05$). However, residents reported slightly lower scores than specialists. Positive ratings were given to interpersonal interactions, with medians of four for teamwork and colleague support and three for the effectiveness of conflict resolution (interquartile range: three to five). The work environment revealed a median score of four for satisfaction with safety protocols (interquartile range: three to five) and a score of three for the appropriateness of equipment and the manageability of tasks (interquartile range: three to four). Sixty-two percent of respondents acknowledge that there are resource limitations that have an impact on patient treatment. Residents reported with a somewhat lower level of satisfaction regarding teamwork and a stronger impact of resource limitations on patient care, when compared to specialists, although the difference was not statistically significant (Mann-Whitney U test, $p > 0.05$).

The participants said that stress related to their jobs was a considerable burden, as it affected more than half of them. Furthermore, the

study revealed a very high level of interpersonal strain. Furthermore, according to the WHO-5 Well-Being Index scores, 43% of participants felt calm and relaxed just some of the time or less. There was a low level of comfort when discussing difficulties related to mental health, with just 19% of respondents feeling comfortable doing so. When compared to specialists, residents had a tendency to report higher levels of weekly stress and a poorer degree of comfort when discussing concerns related to mental health. However, these trends did not achieve statistical significance ($p > 0.05$). The distribution of comfort levels discussing mental health is shown in Chart 3. Furthermore, proposals for development usually included the establishment of psychiatric services within the organization as well as activities that build teams.

Chart 4 presents a graph of the indicators that are associated with burnout and stress among the staff members working in anesthesiology.

Only 23% of respondents agreed that leadership acknowledged the risks of burnout, 28% of respondents felt that their supervisors cared about their wellness, and only 15% of respondents confirmed that they had access to psychological treatments. When compared to specialists, residents reported slightly poorer perceptions of leadership support regarding burnout. However, there was no statistically significant difference between the two groups regarding burnout ($p > 0.05$). Concerning the culture of safety in the workplace, participants claimed that they were not encouraged to disclose problems (median score of 3), and 62% of them confirmed that resource limits had a negative impact on patient safety. There were no significant differences between residents and specialists in terms of workplace culture, mental health indicators, or management support (Mann-Whitney U test, $p > 0.05$). However, we observed a tendency toward higher reported stress among residents, albeit without statistical

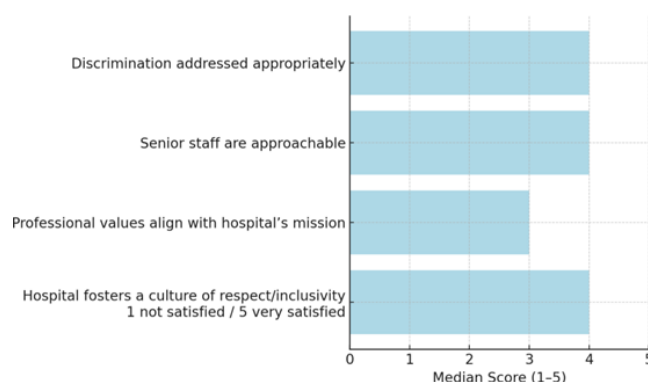


Chart 2. Workplace culture median ratings

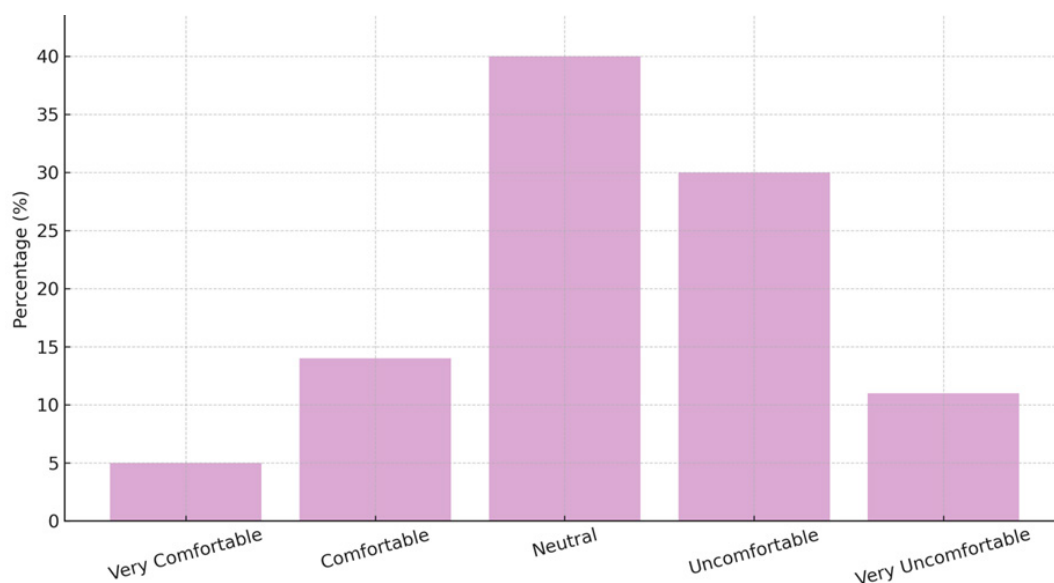


Chart 3. Comfort discussing mental health issue

significance. The fifth chart (Chart 5) provides a comparison of the most important indications of burnout and support between residents and specialists working in different units. A chi-square test was performed, and the results indicated that there was no statistically significant difference in the prevalence of high burnout across the groups ($p = 0.123$). Although there is variation, this shows that it is not strong enough to draw the conclusion that the type of unit has a major influence on burnout according to this sample. Although statistical analysis did not indicate significant differences (Mann-Whitney U test, $p > 0.05$), this comparison reveals a trend toward higher daily work strain and a somewhat lower feeling of institutional support among residents. Despite this, the differences were not statistically significant. It is important to note that residents reported a greater burden of emotional tiredness (WHO-5 proxy) and higher work-related stress in comparison to specialists, although access to psychological support services remained limited

across both groups. Fifty-eight percent of those who participated in the survey stated that they experienced stress linked to their jobs on a weekly basis or more frequently, and 40% of them believed that dealing with people was a daily hardship. According to the proxy question for the WHO-5 Well-Being Index, 43 percent of respondents reported extremely uncommon or non-existent emotions of tranquility and relaxation, which is indicative of emotional exhaustion. Only 23% of participants agreed that hospital leadership was aware of the risks of burnout, whereas 28% of participants believed that their supervisors were concerned about their well-being. In response to a question on resources for mental health, just fifteen percent of respondents acknowledged the presence of psychological help, and fifty percent of respondents were uncertain about the existence of any institutional services. Fourteen individuals (14%), out of a total of one hundred participants, matched the criteria that indicated a high risk of burn-

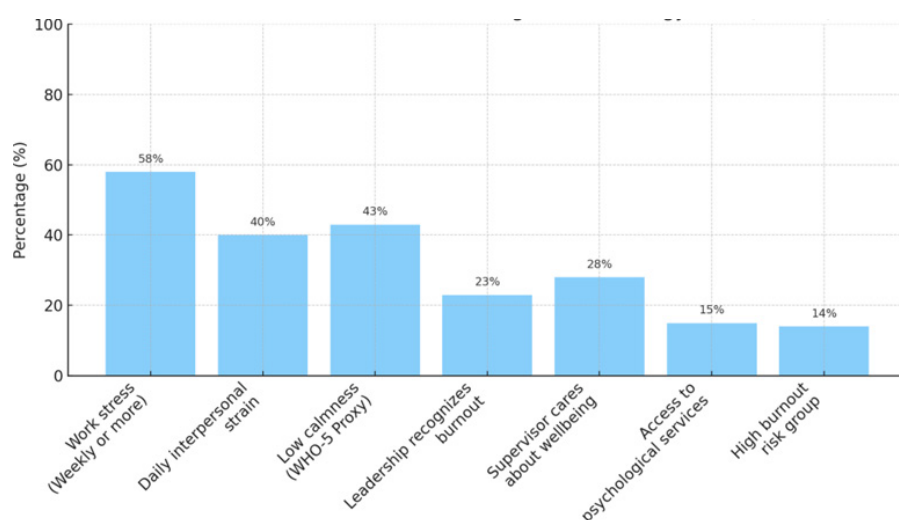


Chart 4. *Burnout and stress indicators among anesthesiologist staff (n=100)*

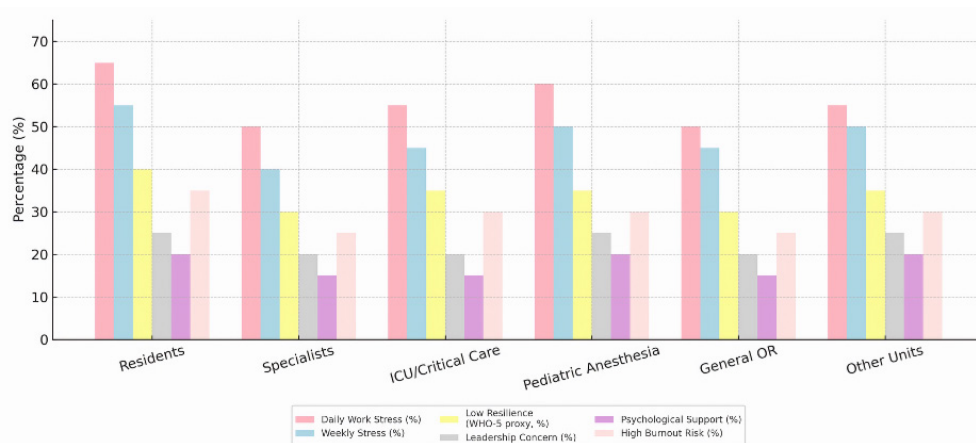


Chart 5. *Burnout and support indicators between anesthesiologist*

out. Burnout is defined as the combination of everyday work strain and the absence or infrequent occurrence of emotions of tranquility and relaxation (based on WHO-5 items). This category represents individuals who are experiencing the highest possible amount of emotional tiredness and tension.

DISCUSSION

Our study emphasizes the importance of workplace environments and institutional support in influencing anesthesiologists' professional satisfaction and emotional health. Residents reported lower satisfaction with managerial communication and fewer perceived opportunities for growth compared to specialists. This decrease occurred even though both groups recognized the importance of clear communication, strong leadership, and resource availability. Similar trends are reported globally. For instance, van der Wal et al. found higher satisfaction and lower stress among anesthesiologists who experienced strong institutional support [9]. West et al. confirmed that unsupportive leadership increases distress and decreases job satisfaction among academic physicians [10].

Quality of life (QoL) for anesthesiologists includes physical health, psychological well-being, and social support. Physically, anesthesiology's demands—long hours, critical decisions, and high-intensity care—contribute to fatigue, musculoskeletal issues, and sleep problems. Significant stress, emotional exhaustion, and burnout are psychologically associated with the role, particularly because of the potentially fatal situations and erratic schedules. Our data show both groups endure mental strain, but residents report higher stress and less perceived mental health support, consistent with Yang et al. [11].

Social support, the third QoL pillar, helps reduce work stress. Effective team communication, supportive leadership, and peer collaboration foster a positive environment. Specialists in our study reported better social support and team cohesion than residents, suggesting institutional factors play a bigger role in perceived well-being. This mirrors global data indicating that workplace culture and administrative backing are stronger predictors of wellness in high-income countries [9].

A country's economic status significantly shapes institutional support in healthcare. In high-income countries (HICs), greater access to resources, structured staffing, and investment in well-being initiatives allow anesthesiologists more autonomy and stronger managerial support. A Turkish study found that structured administrative settings led to higher job satisfaction and reduced burnout risk [12]. In contrast, low- and middle-income countries (LMICs) face common barriers such as insufficient staffing, resource scarcity, and administrative inefficiencies. Our respondents echoed these concerns.

Yang et al. reported that anesthesiologists in Chinese tertiary hospitals lacked institutional support, correlating with greater burnout—even in large urban areas [11]. Similarly, our cohort highlighted mental health service gaps and resource constraints as critical issues. These disparities mirror global LMIC findings and emphasize the need for health system-specific approaches. Enhancing institutional frameworks must consider economic context and local capacity rather than rely on imported models that may not be feasible in resource-limited environments.

Our findings revealed modest job satisfaction overall, with notable differences between specialists and residents. Specialists reported higher fulfillment, likely due to greater job control, recognition, and procedural competence. These elements—autonomy, skill mastery, and peer respect—are widely cited as key drivers of satisfaction. Shanafelt et al. found satisfaction correlated with experience and decision-making authority [13]. In HICs, job satisfaction is often linked to opportunities for academic advancement and flexible work. A Canadian study showed academic involvement and teaching increased satisfaction among anesthesiologists [14]. In LMICs, satisfaction is more often tied to basic job security, working conditions, and interpersonal relationships [15]. This difference highlights the complex nature of workplace satisfaction and the need for context-specific retention strategies. Residents frequently occupy transitional roles characterized by high workload, limited autonomy, and greater emotional vulnerability. Lapa et al. emphasized that emotional regulation mechanisms are especially important early in careers, when job control is limited and dissatisfaction risks are higher [16]. Our data support this: residents, exposed to heavier clinical demands and restricted decision-making

freedom, reported lower satisfaction than specialists. Interventions aimed at improving satisfaction must account for both the professional stage and the local resource setting to be effective and sustainable.

Burnout remains a critical global issue among anesthesiologists, affecting both high-income countries (HICs) and low- and middle-income countries (LMICs), though arising from different systemic pressures. It is a multifaceted psychological condition involving emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment [17]. In our study, residents reported significantly higher levels of emotional fatigue and stress, aligning with previous findings that early-career clinicians are more vulnerable to burnout. Dyrbye et al. found that trainees experienced more depersonalization and poorer work-life balance than their senior counterparts [18]. In LMICs, structural deficiencies, overwhelming patient loads, and lack of institutional psychological support drive burnout. For instance, 68% of anesthesiologists in India reported burnout linked to high workload and insufficient mental health resources [19], while Yang et al. identified similar causes in Northwest China, including workforce shortages and institutional weaknesses [11]. Hierarchical organizational cultures and inefficient workflows further exacerbate the problem in resource-limited settings [11–14, 19, 20]. Conversely, in HICs, burnout is more often driven by bureaucratic demands, fragmented workflows, and the digital burden imposed by

electronic health records [21, 22]. Regardless of context, the mental health consequences are substantial. Ryan et al. reported strong associations between burnout and conditions such as depression, anxiety, and suicidality [23], and De Hert estimated that up to 50% of anesthesiologists may be chronically burned out, posing a threat to both patient safety and workforce sustainability [24]. Burnout has also been linked to increased medical errors and reduced teamwork in high-acuity settings. The COVID-19 pandemic amplified these issues globally, introducing additional stressors such as moral distress, resource scarcity, and staffing shortages, all of which contributed to emotional fatigue, declining job satisfaction, and early retirement considerations [25, 26]. Both HICs and LMICs experienced a surge in psychological distress among anesthesiology personnel. Across settings, a common shortfall is the absence of structured mental health support. Emotional exhaustion impairs clinical decision-making, underscoring the need for systemic solutions [24]. Our findings reflect this reality. Dutheil et al.'s meta-analysis called for globally integrated mental health services as part of comprehensive well-being strategies [25, 27]. Addressing burnout effectively requires a multidimensional approach: improving working conditions, fostering resilience, ensuring access to psychological support, and—critically—eliminating systemic barriers, rather than relying solely on individual coping mechanisms. Reports from the relevant literature summarize the findings of our study in Table 2.

Table 2. *Study findings summarized with literature reports*

Dimension	Residents (Our Study)	Specialists (Our Study)	p-value	HICs (Literature)	LMICs (Literature)
Workplace Environment	Lower perception of support, autonomy, and communication	Higher perception of institutional support	0.032	Better staffing and autonomy, yet bureaucratic strain exists [23]	Understaffing, resource limitations, weak admin support [19]
Job Satisfaction	Lower overall satisfaction, linked to limited control and recognition	Higher satisfaction due to professional autonomy and recognition	0.041	Linked to career advancement, academic roles, flexible work [22]	Driven by job security and interpersonal relations [16]
Burnout & Emotional Wellbeing	Higher emotional exhaustion and work-related stress	Lower burnout, better work-life balance	0.048	Burnout driven by documentation load, patient demands [9]	Burnout due to high workload, lack of psychological support [11]

Note: p-values were calculated using Mann-Whitney U tests for comparisons between residents and specialists.

Several limitations must be considered. First, the study was conducted within a single country, limiting the generalizability of findings across different cultural and health system contexts. Second, the cross-sectional design captures a single moment in time, and longitudinal studies are needed to assess how perceptions of workplace satisfaction, support, and burnout evolve. Third, self-report bias cannot be excluded, as participants may underreport or overreport sensitive issues such as burnout symptoms. Additionally, a self-selection bias may be present due to the voluntary nature of survey participation—individuals experiencing higher or lower levels of burnout may have been more or less motivated to respond, potentially influencing the observed prevalence. Finally, information on the specific type of institution (e.g., university hospital vs. general clinic) was not collected, which may limit interpretation of contextual factors affecting workplace conditions.

Future research should incorporate longitudinal follow-up studies to assess variations in burnout levels and job satisfaction over time, especially in relation to adopted remedies or policy reforms. Such studies would assess the enduring efficacy of organizational modifications intended to enhance the well-being of anesthesiologists and residents.

CONCLUSION

The research highlights the significant influence of job satisfaction on the Quality of Life of anesthesiologists in resource-limited centers. Key findings reveal substantial disparities between residents and specialists, with residents demonstrating elevated stress and burnout levels and diminished views of workplace support. In contrast, specialists indicate heightened job satisfaction and institutional support. To reduce these differences, focused interventions are crucial, especially in resource-constrained environments (LMICs), where systemic obstacles intensify occupational stress. Proposed strategies to enhance the quality of life for anesthesiologists encompass bolstering organizational support for residents via mentorship initiatives and mental health services, instituting structured wellness programs designed to alleviate burnout and enhance work-life equilibrium, and improving

resource accessibility and administrative assistance in low- and middle-income nations to align with global occupational health standards. These strategies are essential for guaranteeing sustainable employment conditions and patient safety throughout diverse economic environments.

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Ethical Approval

The study was approved by the Internal Ethical Review Board.

Appendix A. Participant questionnaire.

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Резиме

БЛАГОСОСТОЈБА КАЈ АНЕСТЕЗИОЛОЗИТЕ: РЕЗУЛТАТИ ОД НАЦИОНАЛНА АНКЕТА

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Вовед: Анестезиологијата претставува клучна медицинска дисциплина во современото здравство, која бара значителен когнитивен напор, продолжено работно време и изложеност на критични ситуации. Грижата за благосостојбата на анестезиолозите е неопходна за одржувањето квалитетна здравствена грижа и стабилна работна сила.

Методи: Спроведена е анкета кај здравствени работници од полето на анестезиологијата во Република Северна Македонија. Користени се следните валидирани инструменти: Прашалник за безбедносни ставови (SAQ), WHO-5 Индекс за благосостојба, како и дополнителни прашања за работната култура, менталното здравје и меѓучовечките односи. Податоците беа собирани анонимно, преку анкетен прашалник креиран и обработен со SPSS v29.0. Спроведени се компаративни анализи за работните услови, психолошкото здравје и индикаторите за професионална исцрпеност.

Резултати: Во студијата учествуваа 100 испитаници: 60 % специјализанти и 40 % специјалисти. Специјализантите покажаа значително повисоко ниво на стрес и исцрпување, со намалена институционална поддршка и нарушена тимска кохезија ($p < 0.05$). Специјалистите пријавија повисоко ниво на професионално задоволство и поголема поддршка од институцијата ($p < 0.05$). Двете групи посочија недоволна ментална поддршка и слаба безбедносна култура, особено во средини со ограничени ресурси; сепак, разликата не беше статистички значајна ($p > 0.05$). Ограничувањата во ресурсите беа генерално препознаени како клучни фактори што влијаат врз проблемите во работната средина во земјите со среден приход ($p < 0.05$).

Заклучок: Студијата открива значајни разлики во индексите на квалитетот на живот меѓу специјализантите и специјалистите по анестезиологија, при што специјализантите доживуваат поголем професионален стрес и пониско ниво на задоволство од работата. Овие разлики се засилени во средини со ограничени ресурси, што укажува на потреба од насочени интервенции за подобрување на благосостојбата, културата на работното место и менталната поддршка за анестезиолозите.

Клучни зборови: анестезиологија, професионална исцрпеност, ментално здравје, професионален стрес, благосостојба

