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“Much of What You Do Goes Unrecognised”: Professional Identity, Power, and Recognition in Anaesthesia across Italy and Malawi

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Research Article

Keywords: anaesthesia profession, professional identity, operating theatre, recognition, power

Posted Date: November 3rd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9529674/v1

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Additional Declarations: No competing interests reported.

TITLE:

***"Much of What You Do Goes Unrecognised"*: Professional Identity, Power, and Recognition in Anaesthesia across Italy and Malawi**

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ABSTRACT

Professional identity formation has gained increasing attention in health professions due to its implications for job satisfaction, work engagement and team cohesion in complex multidisciplinary environments. In anaesthesiology, a well-developed professional identity has been linked to providers' well-being and improved teamwork within perioperative settings. However, the professional identity of anaesthesia providers remains underexplored. This gap is especially relevant in the context of a global shortage of anaesthesia providers, affecting both high- and low-income countries and limiting access to safe surgical care.

Utilising Bourdieu's framework, this study explored how anaesthesia providers construct and negotiate professional identity across contrasting healthcare settings. A qualitative study based on semi-structured interviews was conducted with 32 anaesthesia providers (16 per site) at Queen Elizabeth Central Hospital (Malawi) and Padua University Hospital (Italy). Data were analysed through inductive thematic analysis and interpreted through the Bourdieu's concepts of habitus, capital, and field.

A shared professional habitus emerged across both settings, reflecting common values and professional traits. However, context-specific configurations of capital and field shaped how identity was constructed and negotiated. Notably, a persistent misalignment was identified between high levels of cultural capital and limited symbolic and economic recognition, reflecting embedded power imbalances within surgical environments.

By applying Bourdieu's framework across contrasting contexts, this study highlighted how structural conditions shape professional identity and revealed enduring tensions between professional habitus and the distribution and conversion of cultural and symbolic capital. These findings underscored the need to strengthen not only technical capacity, but also professional recognition to rebalance power and the distribution of capital within anaesthesia.

Keywords: anaesthesia profession, professional identity, operating theatre, recognition, power

Introduction

Professional identity refers to the “representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician” (Cruess et al., 2014). Central elements of an individual’s professional identity include what a professional believes, knows, and does, encompassing the values, knowledge, and practices that shape how individuals understand and enact their professional roles (Fitzgerald, 2020). Professional identity formation is an adaptive developmental process that happens simultaneously at individual level, involving the psychological development of the person, and at collective level, involving the socialization of the person into appropriate roles and forms of participation in the profession’s work (Cruess et al., 2014; Jarvis-Selinger et al., 2012).

The process of professional identity formation has gained greater recognition in health disciplines (Cornett et al., 2023; Cruess et al., 2016), particularly due to its implications for team dynamics in complex multidisciplinary environments (Khalili & Price, 2022). It has been documented that professional identity influences job satisfaction and work engagement (‘Addressing Power Dynamics in Interprofessional Health Care Teams’, n.d.), and shapes the ability to create productive relationships in multidisciplinary teams (Best & Williams, 2019; Lingard et al., 2002). In anaesthesiology, emerging evidence suggests that a well-developed professional identity can contribute to providers’ well-being (Bahaziq & Crosby, 2011; Smith, 2007) as well as to team cohesion and cooperation within perioperative environments (Chin et al., 2024; Lingard et al., 2002; Smith & Mishra, 2010). Despite this evidence, the professional identity of anaesthesia providers remains relatively underexplored, highlighting the need for further investigation into the social and organisational processes that shape how these professionals understand and enact their role.

This gap is particularly relevant in the context of a global shortage of anaesthesia providers, which continues to affect both high- and low-income countries and has significant implications for access to safe surgical care (Keyvanlo et al., 2025; Menezes & Zahalka, 2024; *The NASC Workforce Working Group Addressing Europe’s Anaesthesia Workforce Shortage*, 2026). Understanding how professional identity is constructed and negotiated across different settings is therefore critical to informing strategies aimed at strengthening the anaesthesia workforce and improving retention.

Published literature emphasizes that professional identity is not a fixed or purely individual attribute, but rather is a dynamic and evolving process shaped by multiple interacting factors, including the development of medical competencies, everyday clinical practice, professional hierarchies, and institutional norms (Jarvis-Selinger et al., 2012; Lingard et al., 2002; Santivasi et al., 2022). Analysing these processes requires a theoretical framework capable of capturing these components and their mutual interactions. Bourdieu’s habitus and social capital theories offer a valuable lens for examining professional identity within healthcare settings, as they allow professional identity to be understood not as a fixed attribute but as a socially

constructed position emerging from interactions within a field shaped by institutional structures, power relations and the distribution of different forms of capital (Bourdieu, 2013).

Utilising Bourdieu's framework, this study aims to explore how anaesthesia providers construct and negotiate their professional identity across contrasting healthcare settings, specifically in a high-income country (Italy) and a low-income country (Malawi). These differ substantially in terms of healthcare workforce composition, resource availability, and organisational structures. The study aims to understand how these contextual differences shape the professional positioning of anaesthesia providers. Specifically, it addresses the following research questions: What are the key components of anaesthesia providers' professional identity? How do these components shape anaesthesia providers' professional identity in a high- and low-income country setting?

Bourdieu's sociological theory

Central to Bourdieu's theory are the concepts of field, habitus, and capital, which together allow for an analysis of how different structural conditions shape professional identity development (Swartz, 1997).

Field refers to structured spaces of dominant and subordinate positions that are organised around specific types of capital or combinations of capital (Bourdieu, 2013). A field is therefore a social space where agents (individuals or groups) interact, participating in exchanges and events. Each field is structured by its own rules, hierarchies, and forms of legitimacy, which are often taken for granted by those who participate in it. Agents occupy different social positions within the hierarchy of the field and compete for resources that are valued within that space. Fields are not static; they are shaped by historical processes and ongoing struggles between actors with unequal access to power. Entry into a field requires familiarity with its norms and an implicit understanding of what is considered appropriate, legitimate, or valuable.

Habitus refers to the values, norms, and expectations of particular social groups that are acquired as a result of a long-term occupation of a position in a social world (Bourdieu, 2013; Swartz, 1997). It explains how it is that people act and think in accordance with the social context (Collyer, 2015). In the habitus people's experiences become internalized, and through these experiences they learn the rules that become second nature to them. Thus, in their daily lives, individuals act unconsciously according to their habitus and sometimes make choices and develop strategies as they engage with various social fields, gathering and deploying forms of capital ((Collyer, 2015).

Capital refers to the resources collected by individuals and groups to maintain and enhance their position in the social order. It refers to resources that are valued within a particular field and that can be mobilised to gain advantage or recognition (Bourdieu, 2013; Swartz, 1997). Bourdieu identifies four different types of Capital: i) economic capital, defined as the capital "immediately and directly convertible into money"; ii) social capital, intended to explain how people gain access to powerful positions through social connections. It consists of networks, relationships, and social connections; iii) symbolic capital, based on prestige,

recognition, and honour often derived from other forms of capital and iv) cultural capital, which includes knowledge, skills, qualifications, and embodied competencies (Abel & Frohlich, 2012; Bourdieu, 2013; Swartz, 1997).

Applying Bourdieu's sociological theory to the anaesthesia profession

Bourdieu's sociological theories have been widely applied in healthcare research to analyse complex social phenomena, including access to healthcare systems (Collyer et al., 2017), research in the health sector (Walsh et al., 2016), professional relationships between patients and healthcare providers (Sarkar, 2022), identity formation in medical education (Varpio & Albert, 2013), and the processes influencing medical speciality choice (Ashley & McDonald, 2024; Olsson et al., 2019).

However, the Bourdieusian framework has rarely been applied specifically in the context of surgical care. Within health systems, operating theatres (OT) are complex and dynamic environments where multidisciplinary teamwork is needed to ensure patients' safety and surgical efficiency (Stahel et al., 2022; Watkins & Hensley, 2023). In the OT, different actors (i.e. surgeons, anaesthesiologists, nurses, and trainees) operate within intersecting hierarchies of authority and expertise, where roles, responsibilities, and power are unevenly distributed and continuously negotiated in practice (Salas, 2015; Weller, 2025; Weller et al., 2024).

By applying this conceptual framework to anaesthesia practice, this study aims to provide new insights into the processes that influence how anaesthesia providers construct and negotiate their professional identity. Bourdieu's lens is particularly relevant for the present study, which compares anaesthesia providers working in a high and a low-income healthcare context, where variations in institutional structures, workforce composition, culturally mediated hierarchies and resource availability may significantly influence the configuration of the anaesthesia field and the ways professional identity is developed.

In this research, Bourdieu's field is conceptualised as the medical field, encompassing the broader social and organisational space within which anaesthesia providers operate. In turn, the medical field is defined as the domain of physician practice within healthcare systems, representing a distinct professional space in which physicians organise their work and exercise expertise (Coburn, 2001). The OT is understood as a central arena within this field, but not its sole locus, as professional identity is also shaped by training systems, institutional structures, and health systems. Additionally, anaesthesia practice extends across multiple clinical environments, including intensive care and non-operating room anaesthesia (NORA). Nonetheless, this study focuses specifically on the OT as the central arena of analysis, where surgery is performed within a dedicated surgical environment, as opposed to procedures conducted outside this setting. The OT was selected because it represents the primary site where anaesthesia providers negotiate authority, exercise responsibility, and construct professional identity in direct interaction with other medical and health professionals.

The concept of habitus facilitates an understanding of the values, norms, and expectations that orient anaesthesia providers practices within the specific demands of their professional environment. By analysing habitus, this study highlights how anaesthesia providers internalise the structural conditions of their working environments, and how these internalised components contribute to delineate anaesthesia providers' professional identity.

Within each operating theatre arena, anaesthesia providers mobilise different forms of capital (cultural, symbolic, economic, and social) in their interaction with other professional groups. The value and convertibility of these forms of capital may vary across contexts, particularly when comparing different healthcare settings.

Method

Study design and setting

The first author designed and conducted a qualitative study, with co-authors' support, based on semi-structured interviews with anaesthesia providers working at Queen Elizabeth Central Hospital (QECH), Malawi, and at Padua's University Hospital (Azienda Ospedale - Università), Italy.

QECH is the largest referral and teaching hospital in Malawi and serves as the main clinical training site for the University of Malawi College of Medicine. At the time of the study, anaesthesia services were organised within a single Anaesthesia Department serving the hospital's operating theatre.

Padua University Hospital is a large academic tertiary-care centre affiliated with the University of Padua in northern Italy. In contrast to QECH, anaesthesia services are organised into several specialised anaesthesia departments associated with different surgical units. To capture a broader institutional perspective, participants in Padua were recruited across multiple anaesthesia departments.

These two settings provided contrasting organisational environments to examine how anaesthesia providers construct and negotiate their professional identity within the broader anaesthesia field.

Study sample

Participants were selected using purposive sampling from members of the Anaesthesia Department at QECH and the anaesthesia staff at Padua University Hospital. In total, 32 anaesthesia providers were interviewed, including 16 participants from QECH and 16 from Padua University Hospital.

The following inclusion criteria were applied: physician (consultant and residents, i.e. physicians training to be anaesthesiologists) and non-physician anaesthesia providers (NPAPs) working in the OT at either institution and willing to participate in an interview. As NPAPs are not part of the anaesthesia workforce in Italy, this group was only represented in the Malawian setting. To enhance comparability across contexts,

only anaesthesia providers able to work autonomously in the operating theatre were enrolled. In Malawi, both NPAPs and residents at all stages of training routinely practised with a high degree of autonomy, under the supervision of the hospital's consultants, who oversaw clinical practice at departmental level. In Italy, only residents in their final year of training, and authorised to manage cases independently in the operating theatre under consultant supervision, were recruited.

The first author (E.P.) developed an interview guide based on a review of relevant published studies (Afshar et al., 2021; Chin et al., 2024; Santivasi et al., 2022), which was piloted with six anaesthesia consultants from both high and low-income countries prior to administration (Supplementary file).

Ethics

The study was conducted in accordance with the ethical principles for medical research involving human participants (*WMA - The World Medical Association-WMA Declaration of Helsinki*, 1964). All participants received an information sheet explaining that participation was voluntary, that data would be treated confidentially, and that consent could be withdrawn at any time without providing a reason. Written informed consent was obtained from all participants prior to the interview.

Ethical approval was obtained from the College of Medicine Research and Ethics Committee (COMREC) in Malawi (registration number P.08/23-208) and from the Research Ethics Committee of the Royal College of Surgeons in Ireland (RCSI) (registration number REC202307006).

The Ethics Committee of Azienda Ospedale–Università di Padova reviewed the project and determined that formal ethical approval was not required under the Italian guidelines on observational studies (Gazzetta Ufficiale, 20 August 2024), as the research consisted of qualitative interviews and did not involve clinical interventions or patients' data.

Data collection

Data were collected between May and December 2025 by the first author (E.P), a female consultant anaesthesiologist with training in qualitative research methods. All interviews were conducted by the first author (E.P) with occasional support from other authors (J.G.). Interviews in Malawi were conducted in May 2025, and the corresponding data were analysed between June and October 2025. Interviews in Italy were conducted between November and December 2025, and the corresponding data were analysed between November 2025 and February 2026.

Prior to the study, the first author (E.P.) contacted the heads of Anaesthesia Departments at both institutions to explain the purpose of the research and to inform them about the planned recruitment of staff. Then, she approached potential participants by phone or email to provide information about the study and to arrange a suitable time for the interview. Face-to-face semi-structured interviews were conducted individually in a

quiet room at Queen Elizabeth Central Hospital and Padua University Hospital to ensure privacy and confidentiality.

Before the interview, each participant received an information sheet describing the study and signed a written informed consent form. All interviews were audio-recorded and subsequently transcribed verbatim by the first author (E.P.). To ensure anonymity and confidentiality, transcripts were anonymised using a coding system that removed identifying information and delinked interview data from participants' personal characteristics.

Recruitment continued iteratively until data saturation was achieved, defined as the point at which no new themes emerged from successive interviews (Saunders et al., 2018).

Data analysis

Anonymised transcripts were analysed using the thematic analysis approach described by Braun and Clarke (Braun, 2008). The first author (E.P) started by reading the transcribed interviews repeatedly to achieve immersion in the data and gain an overall understanding of the participants' narratives. After this familiarization phase, an inductive approach was employed to generate initial codes directly from the data. Extracted information was categorised and then pooled together based on similarity in meaning to produce a set of integrated sub themes and themes. Data synthesis and integration were led by the first author (E. P.) and informed through regular discussions with co-authors (J.G., C. P.) to refine the interpretation of codes and emerging themes.

The analysis followed an iterative process, whereby initial codes were progressively refined, merged, or reorganised into broader thematic domains. NVivo (version 15) software was used to support data management, coding, and the development of subthemes and themes (*NVivo by Lumivero | Qualitative Data Analysis (QDA) Software*, 2025).

Results

In Malawi, participants recruited from the QECH Anaesthesia Department included one anaesthesia consultant, eight NPAPs, and seven residents (Table 1). The total duration of the interviews was 12 hours and 15 minutes, with an average interview length of approximately 46 minutes. In Italy, participants were recruited from multiple specialised anaesthesia departments (including general anaesthesia and intensive care, major surgery and transplant anaesthesia, paediatric anaesthesia, and cardiothoracic anaesthesia) to ensure representation across different clinical areas of practice. The Italian sample included ten consultants and six residents (Table 1). The total duration of the interviews were 7 hours and 35 minutes, with an average interview length of approximately 28 minutes.

Table 1. Participants' main characteristics. *NPAPs: Non Physician Anaesthesia Providers.



MALAWI			
INTERVIEWS	**Participants number**		**Years of experience**
	Total	**Partial**	
Anaesthesia Consultants	1		5-10
Anaesthesia Residents	7		< 5
*NPAPs**	8	4	< 5
		4	5-10
Total	16		



ITALY			
INTERVIEWS	**Participants number**		**Years of experience**
	Total	**Partial**	
Anaesthesia Consultants	10	2	> 30
		1	10-15
		6	5-10
		1	< 5
Anaesthesia Residents	6		5
Total	16		

Thematic analysis

Three overarching themes and thirteen subthemes were identified through inductive thematic analysis (Figure 1). The three main themes (Individual, Relational and Societal) represent distinct dimensions contributing to shaping anaesthesia providers' professional identity. Each theme included a set of

subthemes corresponding to specific components influencing professional identity within that dimension (Figure 1).

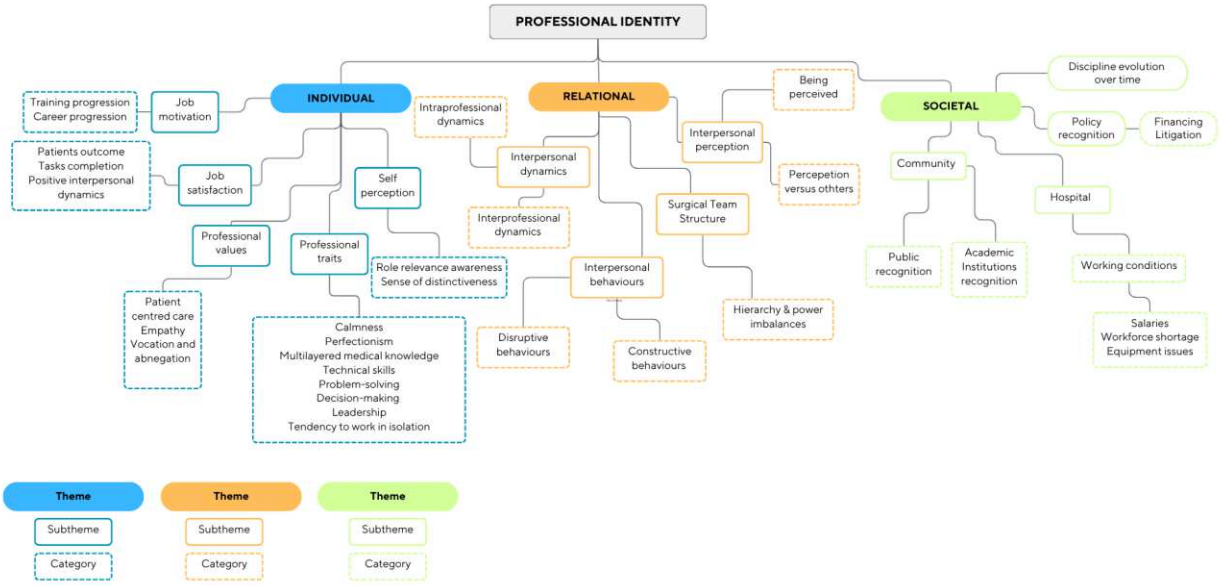


Figure 1. Themes and subthemes identified through inductive thematic analysis, organised into three dimensions (Individual, Relation and Societal). Coloured rectangles represent themes, continuous lines indicate subthemes, and dotted lines denote categories.

An interpretative approach was used to move beyond descriptive categorisation and achieve a more in-depth understanding of the findings. Themes and subthemes were interpreted through Pierre Bourdieu's concepts of habitus, capital, and field. While these concepts are presented in distinct paragraphs for analytical clarity, they are deeply interconnected in practice and continuously interact in shaping anaesthesia providers' professional identity and everyday clinical practice. This theoretical lens enabled the research team to explore how themes and subthemes mutually interact in shaping anaesthesia providers' professional identity. Furthermore, it facilitated the comparison across the Italian and Malawian contexts (Figure 2).

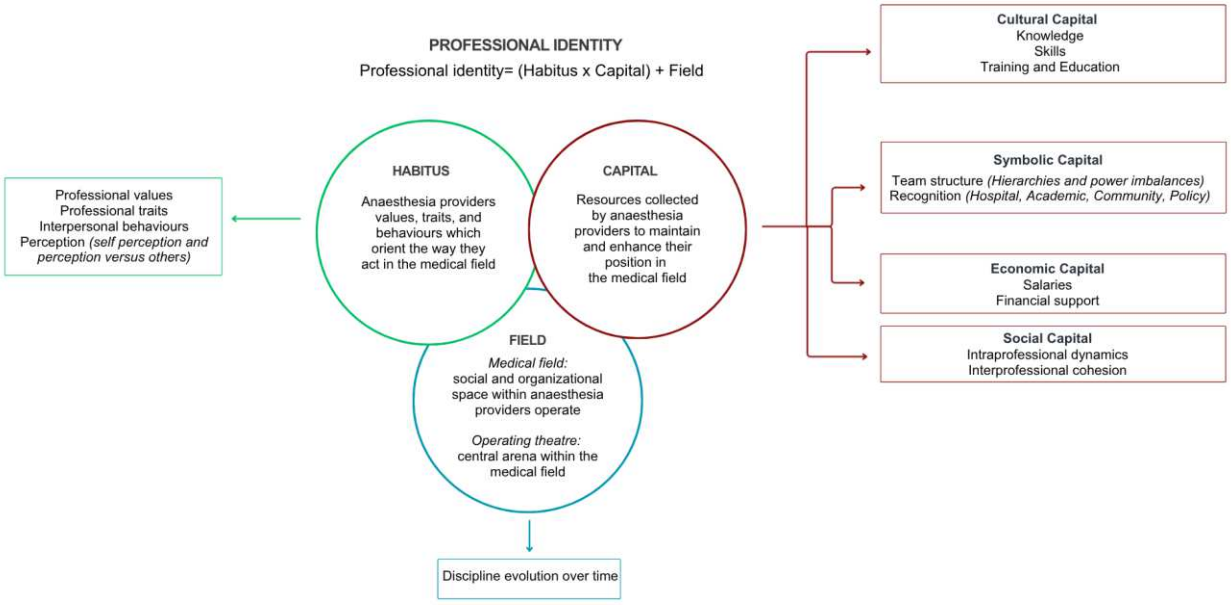


Figure 2. Anaesthesia Providers Professional identity interpreted through Pierre Bourdieu's concepts of habitus, capital (cultural, symbolic, economic, social), and field.

Habitus

Subthemes identified across Individual, Relational, and Societal dimension, and concerning anaesthesia providers' professional traits, values, behaviours, and perceptions, were interpreted through Bourdieu's concept of habitus. This approach enabled an understanding of how these professionals act and interact within their field (Figure 2).

A central feature of the anaesthesia habitus was the ability to manage complex and acute clinical situations. Participants consistently emphasised adaptability, preparedness, and the capacity to remain calm under pressure as defining characteristics of the profession. As one resident explained, there is *"a desire to meet the demands of challenging situations and to be able to manage critical, urgent, and emergency scenarios" (Italy, resident)*. Similarly, another participant described adaptability and emotional control as essential professional traits: *"we are able to adapt and manage in almost any situation… and above all, the ability to remain calm is a real advantage" (Resident, Italy)*.

This orientation was closely linked to practices of anticipation and safety, with anaesthesia providers describing a tendency to prepare extensively before clinical interventions. As one participant noted, *"we are used to having everything well-prepared before starting, because of safety reasons" (Resident, Malawi)*.

Participants also described a disposition toward versatility and broad clinical engagement, emphasising the ability to care for diverse patient populations and clinical conditions. This breadth of practice was perceived as intrinsic to the anaesthesia role: *"you deal with a wide range of people, from the old people to young people to even pregnant women" (Resident, Malawi)*, and *"being able to see patients of all ages with different illnesses" (Consultant, Malawi)*.

This adaptability was closely associated with a strong orientation toward decision-making, responsibility, and leadership, particularly in acute and uncertain situations. Anaesthesia providers described themselves as active decision-makers: *"you make decisions" (NPAP, Malawi)* and, in emergencies, by assuming leadership roles: *"in an emergency situation… I continuously become a leader" (NPAP, Malawi)*. With increasing experience, leadership was described as an embodied and situational disposition: *"you become a leader, and you command whatever is necessary in that situation" (NPAP, Malawi)*.

Participants emphasised having a distinctive disposition centred on empathy and patient-centred care. Anaesthesia providers described entering into close, often intense relationships with patients during moments of vulnerability. A resident in Malawi explained: *"I still maintain the rapport with the patient… continuously talking… and trying to see how I can help those patients" (Resident, Malawi)*, while a consultant in Italy described these interactions as *"a brief yet very intense exchange"* with patients *(Consultant, Italy)*. Participants also expressed a strong sense of responsibility for ensuring patient safety and informed risk evaluation, highlighting their role in providing realistic explanations of anaesthesia risks: *"it's our responsibility to provide a realistic explanation of anaesthesia" (Consultant, Italy)*.

Participants highlighted how professional motivation and satisfaction are often internally constructed, rather than dependent on external recognition. Several of them described a need to accept that their work may remain relatively invisible within the broader medical field, and to derive satisfaction from the quality of care delivered rather than external validation. As one consultant explained, *"what matters… is what I was able to achieve for that patient… and that alone is enough to feel satisfied" (Consultant, Italy)*, while another noted that *"much of what you do will often go unrecognised, and the satisfaction has to be internal" (Resident, Italy)*.

Participants also described their work as centred on managing high-risk patients: *"we don't deal with minor issues… we deal with very sick patients" (NPAP, Malawi)*, and emphasised that their choice of speciality was driven by the perceived importance of their role rather than financial incentives: *"the services are very crucial… particularly for those people who are very ill" (NPAP, Malawi)*.

Finally, they emphasised the personal commitment and sacrifice associated with the profession: *"this job requires making many sacrifices… you sacrifice other things, such as time with family, relationships, social life" (Resident, Italy)*.

Participants described a distinctive interpersonal style, characterised by a non-dominant approach to interactions. Despite operating in high-pressure environments, anaesthesia providers often portrayed themselves as maintaining a composed and measured presence, which was seen as integral to their professional role. As one consultant noted, *"[we] are often quite calm individuals… even if [we] enjoy working in high-stress situations, [we] are generally not particularly imposing in [our] interactions with others" (Consultant, Italy)*.

Interestingly, a tendency to work in isolation emerged across both countries, reflecting not only structural constraints within the field (such as limited support and recognition) but also the internalisation of conditions such as isolation into dispositions of self-reliance or withdrawal, which become part of the anaesthesia habitus.

On the negative side, as one participant noted, *"There was no such assistance, so you were doing everything by yourself" (consultant, Malawi)* highlighting how organisational short-comings necessitate autonomous practice. Similarly, another participant described that *"Experiences of exclusion tend to reinforce further marginalisation within the system, leading individuals to withdraw" (Consultant, Italy)* illustrating how structural marginalisation can be internalised as a tendency to work in isolation with reduced engagement in the surgical team.

These dynamics also underpin how anaesthesia providers perceive and relate to other professional groups. Perceptions of other professionals, particularly surgeons, revealed contrasting approaches to patient care. Participants described surgeons as primarily focused on the technical act of operating, sometimes at the expense of broader clinical considerations: *"they want to make sure that they operate the patient, but sometimes you find that they are not considering the safety of the patient"* (NPAP, Malawi). Similarly, another participant reflected on perceived ways of acting: *"In my view, surgeons have a particular way of seeing the patient, along with a certain lack of expertise in managing various clinical aspects, such as vital functions and pharmacology. Personally, I have observed several shortcomings among surgical colleagues, who tend to focus primarily on the manual and practical aspects of surgery itself" (Consultant, Italy)*.

These findings can be interpreted through Pierre Bourdieu's habitus concept, reflecting distinct, socially acquired dispositions that shape how different professional groups understand and manage patient care. At the same time, these differences are embedded within the broader structure of the field, where professional boundaries and hierarchies contribute to the emergence of contrasting clinical logics and interprofessional tensions.

Capital

Subthemes within Individual, Relational, and Societal dimensions, relating to training, resources, and professional recognition, can be understood through the concept of capital, encompassing the forms of

knowledge, social connections, and symbolic value that anaesthesia providers mobilise within their practice (Figure 2).

Cultural Capital

Cultural capital emerged as central to the identity of anaesthesia providers yet unevenly recognised within the field. Several participants emphasised the intellectual and clinical complexity of the speciality, highlighting its comprehensive scope and strong grounding in physiology and pharmacology. As one consultant noted, anaesthesia offers *"a truly comprehensive, 360-degree view of the patient" (Consultant, Italy) enabling practitioners to manage a wide range of clinical situations",* while a resident described *"the ability to observe immediate physiological responses and engage deeply with pharmacological and physiological processes" (Resident, Malawi)*.

Participants also highlighted the complexity and depth of the cultural capital required in anaesthesia, describing it as a combination of practical, technical, and highly theoretical knowledge. As one resident explained, *"it is a practical job… but also highly theoretical because it involves calculations, working with numbers, and managing dosages in a very precise way"*, emphasising the integration of manual skills with advanced cognitive and analytical competencies. This multidimensional expertise was often perceived as a distinctive and intellectually engaging feature of the speciality.

In addition, participants underscored the importance of being able to mobilise this knowledge in high-stakes clinical contexts. As one resident noted, anaesthesia requires *"being able to meet the demands of complex situations and effectively manage critical, urgent, and emergency scenarios*" (Resident, Italy) highlighting the role of cultural capital not only as accumulated knowledge, but as the capacity to apply it rapidly and effectively in dynamic and unpredictable environments.

However, participants also underlined how this expertise is not always fully recognised or valued within the broader peri-operative field. In some cases, anaesthesia providers reported a frustrating disconnect between actual competencies and perceived professional status, as one participant explained, *"it will be hard for me to be promoted… because I'm appearing as a nurse" (NPAP, Malawi)*.

The acquisition of cultural capital was also described as a source of vulnerability during early stages of training. Participants described experiences of being *"subtly undermined… due to the lack of experience at the early stages of training"* (*Resident, Italy)*, as well as being left alone in challenging clinical situations, leading to *"a profound sense of frustration and inadequacy" (Resident, Italy)*.

Several participants highlighted how limited opportunities for professional progression and access to training may discourage sustained engagement with the speciality and reduce motivation to further invest in it. As one participant noted, *"that's what drives many people away… people may feel they are not going*

to progress further" (Malawi), suggesting that restricted pathways for skill development and career advancement can negatively affect both individual motivation and workforce retention.

Learning was described as inherently motivating, yet often dependent on individual effort rather than institutional support. Finally, participants highlighted the need for a more enabling environment, noting a need for *"a more supportive environment for growth, without constantly having to carve out space for it with difficulty" (Consultant, Italy)*.

Symbolic Capital

Participants consistently described the OT arena as structured around the centrality of surgeons, who occupy a dominant position characterised by greater authority and visibility. Across both low and high-income contexts, surgeons were frequently portrayed as the primary actors within the operating theatre, shaping the organisation of work. As one participant in Malawi noted, *"in the operating theatre, the surgeon has been taken as the paramount chief, the overall boss" (Resident, Malawi)*, while an Italian consultant similarly described how *"anaesthesiologists often experience a sense of subordination in relation to surgeons" (Consultant, Italy)*.

This hierarchical positioning was further reinforced by the perception of anaesthesia as a service-oriented speciality, existing to support surgical practice, rather than as an autonomous domain. As one participant explained, *"it is a type of work that is often perceived as a service. It exists because there are other professional roles to which it is, in some way, subordinate or supportive" (Consultant, Italy)*. In practical terms, this imbalance of symbolic capital was reflected in everyday practices within the OT, including limited involvement in surgical processes. For example, one participant described how *"surgeons…change the theatre list without telling the anaesthesiologist" (NPAP, Malawi)*, highlighting the asymmetry of authority in clinical organisation.

Participants also linked the dominance of surgeons to their position within the broader patient's pathway. Surgeons were often described as the first point of contact for patients and as maintaining continuity of care beyond the OT, reinforcing their centrality within the field: *"the surgeon meets the patient before I meet him… and continues monitoring until discharge" (Resident, Malawi)*. This longitudinal involvement contributes to the accumulation of symbolic capital, positioning surgeons as the primary reference point in the patient's trajectory.

However, despite this structurally dominant position, from first outpatient appointment to post-operative discharge from hospitals, participants emphasised the critical role of anaesthesia in ensuring surgical safety and patient outcomes. As one Italian consultant noted, *"we are a key piece in the surgical pathway because poor anaesthesia leads to problems… we are the ones who have to step in and stabilise the situation" (Consultant, Italy)*. Similarly, participants in Malawi highlighted that *"without anaesthetics, no procedure is*

needed… for very sick patients… the anaesthetist has to be there" (NPAP, Malawi), indicating their high recognition of the indispensable role of anaesthesia.

Participants also highlighted how symbolic capital within the field is closely linked to the historical distribution of cultural capital, particularly in relation to professional status and training pathways. In Malawi, anaesthesia was historically provided largely by NPAPs, i.e. non-physicians, while physician surgeons occupied positions within the formal medical training pathway, legitimised by the Medical Council. As one participant explained, *"surgeons… have seen us through undergrad… and then now you become a specialist. Their respect is still going to be there" (Resident, Malawi).*

At the same time, this evolving position in OT is also shaped by broader social hierarchies, including respect for seniority and established authority structures. As one resident noted, even when professional recognition increases, *"if the senior surgeon is a bully… it becomes tough for you to stand up… because in our society, we are raised to be very respectful" (Resident, Malawi)*, highlighting how symbolic capital is also embedded within wider social norms.

Anaesthesia providers reporting getting greater acknowledgment among nurses and other clinical colleagues working outside the OT. In Malawi, participants reported that anaesthesia providers are often perceived as essential by other healthcare professionals. As one participant noted, *"anaesthesia providers look important because… no surgery can happen… if the anaesthetist is not there" (NPAP, Malawi)*, highlighting a form of practical recognition grounded in the indispensability of their role.

This institutional under-recognition was further reflected in how anaesthesia providers are positioned within hospital organisational structures, where their professional identity is often reduced to functional roles. One consultant described how *"we are seen as nothing more than numbers needed to keep the system running… treated as interchangeable units… with no real recognition of individual career paths or specific competencies" (Consultant, Italy)*.

Recognition appeared to vary significantly across different levels of the field, with substantially lower visibility and valuation at the institutional level of hospital management. As one participant noted, *"while our work is recognised by [OT] colleagues, at higher levels, particularly among those in managerial roles, there tends to be less consideration compared to other specialities" (Consultant, Italy)*. This dynamic was often attributed to management priorities that favour surgical services over anaesthesia. As one consultant reported, "*We face significant challenges with the medical leadership [of this hospital], which tends to strongly support the surgical role" (Consultant, Italy).* These accounts suggest a limited conversion of cultural capital, such as expertise, experience, and specialised knowledge, into symbolic capital at the organisational level.

Participants also highlighted how symbolic recognition is constrained by a persistent cultural framing of anaesthesia as an activity confined to the OT. As one consultant explained, *"there remains a cultural legacy that associates the role of the anaesthetist almost exclusively with activity in the operating theatre" (Consultant, Italy),* leading to the under-recognition of their broader involvement in high-intensity clinical settings outside the OT. Similarly, another participant stated *"that senior paediatricians, and some trainees, tend to feel superior. I don't know whether it is because the head of the department is a paediatrician, and therefore they feel somewhat protected in being a bit superior, but what I notice is that the work of the anaesthetist is given little consideration" (Consultant, Italy).*

Participants described a similar pattern of misrecognition, particularly in relation to patients' perceptions. Anaesthesia providers were often perceived as secondary actors within the surgical pathway, with limited awareness of the complexity and responsibility of their role. As one participant explained, *"patients tend to see the surgeon as the one doing the work, and us as just putting them to sleep… except when something goes wrong, and then we suddenly become central" (Consultant, Italy)*. In Malawi, participants also emphasised the lack of public awareness, noting that *"there's little information being distributed to the public about anaesthesia" (Resident, Malawi)*.

Misrecognition also extended to professional status, with some participants describing how anaesthesia providers are sometimes perceived as non-physician or technical staff. As one consultant reported, "*many people perceive us as more similar to nursing or technical staff… assuming that we have not undergone a training pathway as extensive as other specialists" (Consultant, Italy)*.

These dynamics of limited visibility and recognition were also reflected in career choice and recruitment patterns. Participants in Malawi noted that *"most people go for surgery" (Consultant, Malawi)*, while limited exposure during training further reduces interest in anaesthesia: *"as an undergrad, you only get two weeks exposure to anaesthesia" (Consultant, Malawi)*. Similarly, Italian participants emphasised how the speciality remains under-recognised within medical education, with one noting that *"during my training the role of the anaesthetist was not even presented among the various specialities" (Resident, Italy)*.

However, in the Italian context, this reduced attractiveness was not limited to anaesthesia alone but extended to other traditionally demanding specialities, including surgery. Participants linked this trend to broader generational shifts in values, with increasing preference for specialities that offer more balanced lifestyles in terms of time balance and financial stability, such as outpatient-based fields. As one participant explained, *"the generational approach to medicine is changing… people are increasingly choosing specialities that offer a more balanced lifestyle" (Consultant, Italy)*.

Italian participants also highlighted how limited symbolic capital is compounded by medico-legal and legislative factors that shape the perceived risk of the profession. Some of them described anaesthesia as characterised by high levels of responsibility and legal exposure, often without equivalent recognition or

institutional support. As one participant noted, *"medico-legal concerns frequently place anaesthetists in challenging situations, including complex litigation, which may contribute to a tendency to avoid assuming responsibility" (Italy, consultant).* Another emphasised that the speciality *"from a legislative perspective, it is not comparable to other specialities, considering the level of risk involved, which is considerable. Sometimes this creates a degree of fear because there are situations where the risks are very high" (Italy, consultant).*

Economic Capital

Participants described economic capital as a key factor shaping both the practice of anaesthesia and its positioning within the healthcare system, with important differences emerging across contexts. In Malawi, economic constraints were closely linked to resource availability, training opportunities, and external funding dependencies. Participants highlighted how anaesthesia services often rely on unstable funding streams, noting that *"in the past, we used to depend on donors… now donors are falling out" (NPAP, Malawi)*, with direct implications for both training and service provision. Limited institutional investment further constrained practice, as *"the government will not give you anything" (NPAP, Malawi)*, and clinical work was frequently affected by equipment shortages, with *"supplies [being] erratic… you may have this drug today, tomorrow you may not have it" (NPAP, Malawi)*.

These structural limitations also extended to training pathways, where anaesthesia appeared less financially supported compared to other specialities: "*those doing other specialities usually have a full scholarship… but in anaesthesia, there is none" (NPAP, Malawi)*. The withdrawal of external funding was described as further exacerbating these challenges, contributing to concerns around workforce retention: *"We had …scholarships from America, and we have seen [donors] phased out. So many students now are disadvantaged. So we know maybe there are some people that after being graduated they go out. But still, there are some people that they want to stay! (Malawi, brain drainage (NPAP, Malawi)*. Within this context, anaesthesia was often perceived as a *"profession which is not more rewarded" (NPAP, Malawi)*.

Participants in both Malawi and Italy also highlighted disparities between public and private sectors, noting that *"there's more money… in the private sector" (Resident, Malawi)*, suggesting that economic capital is unevenly distributed within the field.

In Italy, economic capital was primarily discussed in relation to remuneration and its perceived mismatch with the level of responsibility and risk associated with the speciality. Participants reported that anaesthesia is insufficiently rewarded, contributing to its reduced attractiveness: *"it is a profession that has lost some of its appeal… perhaps because… it is not sufficiently well paid" (Consultant, Italy)*. This perceived imbalance between effort, risk, and financial compensation was also linked to quality of care, with one participant noting that *"being better paid would lead to a significant improvement in the quality of our work" (Consultant, Italy)*.

Social Capital

Compared to other forms of capital, social capital emerged less prominently in findings analysis, and the data did not provide a comprehensive or in-depth understanding of anaesthesia providers' networks. However, some useful insights suggest that social capital plays a role in shaping professional positioning and recognition.

At the intra-professional level, important differences concerning the internal dynamics within the anaesthesia professional group emerged across the low and high-income settings explored. In Malawi, participants consistently described strong intra-professional cohesion and mutual support across the different anaesthesia cadres (consultants, residents, and NPAPs), reflecting both the relatively small size of the workforce and the shared experience of building the profession. As one resident noted, consultants *"trust me… if you have got an issue, you can explain to them… they can just come and chip in,"* while a NPAPs talking about residents emphasised that *"we have a good relationship… we respect them, and they respect us… whenever I have a problem, I consult them" (NPAP, Malawi)*.

In contrast, Italian participants described more fragmented intra-professional dynamics, that is among anaesthesia professionals, including elements of comparison and competition among colleagues. As one consultant observed, *"within the team, relationships are not always positive… there is a tendency to speak negatively about colleagues, often suggesting that one could have managed the situation better" (Consultant, Italy)*. Participants also highlighted how this lack of cohesion may weaken the collective positioning of anaesthesia within the broader OT arena. As one participant noted, *"if the group were more united and had a shared strategy, it would likely be able to position itself differently in relation to surgeons and nurses" (Consultant, Italy)*.

Beyond intra-professional dynamics, participants in Malawi highlighted the importance of having individuals who can act as intermediaries between anaesthesia providers and institutional leadership. As one participant noted, *"there are people who can explain that to them, to the administrators… the strategies are there" (NPAP, Malawi)*, suggesting the relevance of relational connections in influencing institutional recognition. At the same time, participants also pointed to limitations in broader engagement across professional groups, with one resident noting that *"we are not really being proactive about getting other specialities to bring in their ideas"*, and another describing anaesthesia as operating *"as a solo entity" (Consultant, Malawi)*. These findings suggested relatively weak inter-professional networks and limited collaborative engagement, which may constrain the accumulation of social capital within the field.

In the Italian context, participants referred to more formalised attempts to strengthen social capital through professional associations. For example, the creation of regional organisations was described as a strategy to improve recognition and visibility among hospital managers and policymakers. These initiatives

highlighted efforts to build collective networks and enhance the profession's influence at institutional and political levels.

Field

Subthemes highlighting anaesthesia discipline development over time, organisational structures, and hierarchies, can be interpreted through the concept of field, referring to the structured social space in which the anaesthesia profession develops and its providers operate (Figure 2).

Across both Malawian and Italian contexts, participants highlighted how anaesthesia has historically held a relatively marginal position within the medical field. In Malawi, this marginality was closely linked to the historical organisation of the workforce, where anaesthesia services were largely provided by non-physician providers and where physician-trained consultants were relatively few. As one resident explained, *"the surgical side dominates more than the anaesthesia side… for a very long time here in Malawi, anaesthesia was being provided by technicians… the majority are the non-physicians" (Resident, Malawi)*. Participants further emphasised how the authority of surgeons was historically consolidated through long-established training pathways and seniority, as *"most of the surgeons… are seasoned and senior to us… they have seen us through undergrad" (Resident, Malawi)*. Whereas anaesthesiology as a medical speciality is relatively new.

Despite this historically subordinate positioning, participants across both contexts described a process of transformation in the role and recognition of anaesthesia. In Malawi, this shift was associated with the development of specialised training programmes and the gradual consolidation of anaesthesia as a distinct professional field. As one participant noted, *"previously, anaesthesia was below all the other departments, but now it has excelled" (NPAP, Malawi)*, reflecting an ongoing process of professionalisation and increasing institutional recognition.

A similar historical trajectory was described in Italy, where anaesthesia was traditionally perceived as a secondary discipline, primarily responsible for *"putting patients to sleep" (Consultant, Italy),* and therefore positioned as subordinate to surgical practice. However, participants also described a gradual improvement in professional recognition linked to the accumulation of competencies and expertise. As one consultant explained, *"historically, the anaesthetist was considered a secondary figure… today… the relationship has become very different" (Consultant, Italy)*.

The COVID-19 pandemic emerged as a critical moment accelerating this shift, significantly increasing the visibility of anaesthesia among both the public and medical students. As one participant noted, "*During COVID-19, more people began to understand what anaesthetists do. Compared to the pre-COVID period, now people at least know what intubation means… But it took a pandemic for that to happen" (Consultant, Italy).* This increased visibility also influenced career speciality choices, as reflected by a resident who

stated, "*Before starting my speciality training, I worked for a year in freelance practice during the COVID-19 period, where I met two anaesthesia residents who described what the job was like, and that's when I realised it was what I wanted to do" (Resident, Italy).*

Finally, participants described the future of the anaesthesia field as one of expansion beyond the traditional boundaries of the OT, although important differences emerged across contexts. In Malawi, this future was framed in dynamic and forward-looking terms, reflecting the relatively recent development of the profession and its ongoing consolidation. Participants emphasised the growing involvement of anaesthesia providers in perioperative medicine, critical care, pain management, and obstetrics, suggesting a process of expanding jurisdiction and increasing relevance within the medical field. As one participant noted, *"the trajectory is definitely upwards. There's a lot of room for us to rise. We can very much be relevant" (NPAP, Malawi)*, while another highlighted that *"our role is not just confined to one department… there's a lot of room for us" (Resident, Malawi)*.

Italian participants expressed a more constrained and less dynamic view of the future, shaped by the perceived rigidity of an already established system. While the scope of anaesthesia practice has broadened over time, participants reported that structural transformation remains limited, as strict hierarchical structures continue to shape the field. As one consultant reflected, *"I imagine that it is difficult for anyone to have to reconstruct a system that has always been this way" (Consultant, Italy)*.

Discussion

This study offers new insights into how anaesthesia providers understand, negotiate, and enact their professional roles within the medical field. By providing an in-depth, theory-informed analysis of anaesthesia providers' professional identity, it contributes to the existing literature, where this topic remains under-explored (Chin et al., 2024; Galante, 2023; Petersen et al., 2024).

The application of Pierre Bourdieu's concepts of habitus, capital, and field provides a structurally grounded understanding of how professional identities are negotiated and constrained within the medical field (Bourdieu, 2013; Swartz, 1997). This approach advances the existing literature on professional identity formation, where the application of Bourdieu's theory remains limited, particularly within anaesthesia.

A further key strength of this study lies in its comparative design, which provides novel insights into how professional identity is shaped across high- and low-income contexts. The existing body of literature shows a lack of knowledge concerning anaesthesia professional identity in low-income settings (Keyvanlo et al., 2025), and the current global surgery challenges related to insufficient anaesthetic workforce underline the need for further research in this area (Gajewski et al., 2020; Khan & Karim, 2023).

Overall, the results indicate both common and context-specific dynamics. The similarities point to a shared professional habitus among anaesthesia providers, shaped by comparable professional traits, values, and role expectations across both settings. At the same time, important differences emerge in how these

components were experienced and negotiated, reflecting context-specific configurations of resources, training pathways, and health system constraints, which may hinder the conversion of cultural, economic and social capital into symbolic recognition. These similarities and differences are discussed in greater detail in the following sections.

The findings highlight how the stage of development of the anaesthesia discipline within the broader medical field shapes the construction of professional identity. Across both contexts, participants linked the relatively low recognition of anaesthesia to its historical positioning within surgical care. This aligns with existing literature documenting the 'birth' of the anaesthesia profession as a subordinate speciality, made up of apprentices chosen by surgeons in an era where surgeons had full control of the OT (Bryan & Kolarzyck, 2020).

Significant differences also emerge across Malawian and Italian contexts. In Malawi, the anaesthesia discipline appears relatively young, in a phase of consolidation characterised by greater intra-professional cohesion, fluidity in professional roles, and ongoing opportunities to renegotiate professional boundaries. This context enables stronger collective engagement and a greater potential to reshape professional positioning within the medical field. In contrast, the Italian context reflects a more institutionalised and historically sedimented field, where professional roles and hierarchies are more stable but also more rigid, contributing to fragmented intra-professional relations and greater resistance to structural change despite increasing levels of expertise.

In Bourdieusian terms, these findings suggest that while anaesthesia providers in both settings are engaged in accumulating different forms of capital and redefining their position within the field, the capacity to transform the structure of the field itself is greater in emerging contexts than in more established ones. This comparison highlights how the stage of field development influences the distribution and convertibility of capital, and ultimately, shapes the formation and enactment of professional identity.

Across both Italy and Malawi, anaesthesia providers demonstrate a similar professional habitus characterised by clinical vigilance, adaptability, and a strong sense of responsibility for patient safety, suggesting that core characteristics of the speciality may transcend contextual differences. This finding is consistent with previous research highlighting common professional values and orientations among anaesthesiologists across settings (Wong, 2011).

However, habitus is shaped by unequal access to different forms of capital. In particular, the findings highlight a persistent misalignment between the high levels of cultural capital held by anaesthesia providers, manifested in complex technical expertise and the ability to manage critical situations, and their comparatively limited symbolic capital within the medical field. While anaesthesia providers possess substantial cultural capital, its recognition and conversion into symbolic capital remain inconsistent, contributing to ongoing challenges in professional recognition. This gap was evident in experiences of

under-recognition at societal levels, where anaesthesia continues to be perceived as a secondary or service-oriented speciality.

These findings are consistent with existing literature documenting the relative invisibility of anaesthesia providers within healthcare systems (Lederer, 2004). Previous studies highlighted how anaesthesia professionals remain under-recognised in relation to surgeons (Kirschbaum, 2012), patients (Hariharan et al., 2006), and other healthcare professionals (Bhattarai et al., 2012), despite their central role in ensuring patient safety. This under-recognition has been linked to entrenched power imbalances within the operating theatre, where surgical authority often dominates decision-making, as well as the inherently low visibility of anaesthesia work, which frequently takes place “behind the scenes” (Kirschbaum, 2012). As a result, the value of anaesthesia expertise is often insufficiently acknowledged across clinical, institutional, and societal domains, reinforcing its marginal positioning within the medical field.

Interestingly, in Italy the findings suggest that the relative status of anaesthesia is influenced not only by its symbolic capital, but also by broader generational transformations in the values structuring the medical profession. Participants underlined that anaesthesia was associated with significant legal and professional risk that is not matched by corresponding symbolic recognition or institutional protection, contributing to its relative devaluation within the hierarchy of specialities. These findings align with recent evidence, indicating that newer cohorts of physicians, particularly Generation Z, are reshaping expectations around medical work, placing greater emphasis on work-life balance and professional recognition (Doise & De Hert, 2025; Elenga & Krishnaswamy, 2023; Kanste et al., 2025).

These shifts appear to reflect a wider change in professional expectations and priorities, where increasing medico-legal pressures, concerns around work-life balance, and perceived lack of recognition are influencing career choices (Petrucci et al., 2021; Shinde et al., 2021). Importantly, this changing landscape does not affect anaesthesia alone, but extended to other high-responsibility specialities such as surgery (Brügge et al., 2024; Chen et al., 2023; Weiss et al., 2024). Participants’ accounts suggest that this imbalance between responsibility, risk, and recognition may contribute to growing challenges in the recruitment and retention of both anaesthesiologists and surgeons. In Bourdieusian terms, when symbolic capital fails to adequately compensate for high levels of responsibility and risk, the attractiveness of these roles within the field may decline, with implications for workforce sustainability and the future organisation of surgical care.

Economic capital further shapes the positioning of anaesthesia within the medical field by structuring the conditions under which practice is carried out and by influencing the relative attractiveness and sustainability of the speciality. The findings suggest that economic capital plays a central role in shaping the attractiveness, sustainability, and everyday practice of anaesthesia. In Bourdieusian terms, limited economic capital (resource scarcity, unstable funding, or insufficient remuneration) constrains both the

accumulation and the effective conversion of other forms of capital, ultimately influencing the position of anaesthesia within the medical field.

Across both Italy and Malawi, though more so in the latter, resource constraints, unstable funding, and limited remuneration are found to shape everyday practice environments and influence the broader attractiveness and sustainability of the speciality. However, important contextual differences emerge. In Malawi, economic constraints are more pronounced, directly affecting the availability of essential resources, staffing levels, and the capacity to deliver safe anaesthesia care. In contrast, while resource limitations are less acute in Italy, disparities between public and private sectors highlight internal inequalities, influencing career trajectories, working conditions, and professional opportunities.

Recent studies demonstrate that workforce shortages, limited institutional support, and resource constraints continue to shape the availability, sustainability, and professional positioning of anaesthesia providers globally (Keyvanlo et al., 2025; Pinelli et al., 2025). This reinforces the argument that economic capital does not operate in isolation, but interacts with wider systemic factors that constrain both the accumulation and conversion of other forms of capital, ultimately influencing the position of anaesthesia within the medical field. Taken together, these findings suggest that the marginal positioning of anaesthesia providers is not solely a matter of professional perception, but is structurally embedded in the unequal distribution and conversion of capital across the field.

Although social capital emerges less prominently in the data, it provides important insights into how anaesthesia providers mobilise relationships and networks to negotiate their position within the field. Findings suggest that intra-professional cohesion, inter-professional engagement, and collective organisation significantly influence the capacity of anaesthesia providers to build alliances, strengthen their professional voice, and improve their positioning within the field. This aligns with recent literature, which highlights how intraprofessional support and broader relational networks play a crucial role in enabling anaesthesia providers to navigate professional challenges and gain recognition, particularly in low resource settings (Edgcombe et al., 2025).

Notably, contrasting patterns emerge between the two settings. In Malawi, stronger forms of intra-professional cohesion were observed, with anaesthesia providers demonstrating a greater sense of collective identity and mutual support, likely shaped by shared challenges, resource constraints, and the need for collaboration in resource-limited environments. This cohesion appears to facilitate the mobilisation of social capital, enabling providers to reinforce their role and navigate complex inter-professional dynamics more collectively. This finding is particularly relevant in the context of low-income settings, where anaesthesia care is largely delivered by NPAPs who assume responsibilities traditionally carried out by physicians due to workforce shortages.

Published literature highlights how such task-shifting arrangements are often characterised by unequal power relations between NPAPs and physicians, linked to differences in educational background, authority, and professional legitimacy, and can generate tensions within surgical systems (Chinguwo, 2025). In this context, the stronger intra-professional cohesion observed among anaesthesia providers in Malawi may represent a key resource for navigating these structural inequalities, enabling collective support, reinforcing professional identity, and strengthening their capacity to negotiate recognition within the field.

In contrast, the Italian context is characterised by more fragmented forms of social capital, with evidence of intra-professional divisions, competition, and, in some cases, rivalry. These dynamics appear to limit opportunities for collective organisation and weaken the ability of anaesthesia providers to act as a unified professional group. As a result, the mobilisation of social capital in Italy is more constrained, potentially undermining efforts to strengthen professional recognition and influence within the broader medical field.

Overall, these findings advance current understandings of professional identity formation by demonstrating that anaesthesia providers' identities are shaped by a persistent structural tension between high and intense levels of clinical responsibility and limited recognition. By adopting Pierre Bourdieu's theory of practice, this study highlights how professional identity is not solely an individual or relational construct, but is deeply embedded in the unequal distribution and conversion of habitus, capital, and field. The findings show that while anaesthesia providers possess substantial cultural capital and share core professional dispositions across contexts, their ability to translate these into recognition and influence remains restricted by structural factors, including power imbalances, resource distribution, and limited visibility within healthcare systems.

Importantly, these dynamics have implications beyond professional identity, affecting workforce sustainability, recruitment, and the organisation of surgical care across both high- and low-income settings (Keyvanlo et al., 2025). Addressing these imbalances therefore requires moving beyond individual or educational interventions towards systemic changes that enhance the recognition of anaesthesia within the medical field.

From a broader perspective, this includes strengthening professional networks, improving the distribution of economic resources, and facilitating the effective conversion of cultural and social capital into symbolic capital. Such changes are essential not only to support anaesthesia providers' professional development, but also to ensure the resilience and safety of surgical systems more broadly. Greater attention should be given to speciality advocacy, particularly during medical school and the early postgraduate years, which represent critical years for shaping career perceptions and professional aspirations. Early exposure to anaesthesia may play a key role in countering persistent misperceptions towards this profession and attracting future practitioners.

Limitations

This study has limitations that should be considered when interpreting the findings. First, the sample was heterogeneous, including participants with different professional roles, levels of experience, and training backgrounds, which may have influenced (but should have added to) the variability of perspectives captured. While this diversity enriched the dataset, it may also limit the comparability of experiences across participants. Nevertheless, interviews were conducted until the point of data saturation for the main themes, reducing the likelihood that important perspectives were omitted.

Second, the study provided a cross-sectional perspective of anaesthesia providers' experiences and did not capture how professional identity develops and evolves. Therefore, it cannot fully account for the dynamic processes through which habitus and different forms of capital are accumulated, negotiated, and transformed across the career trajectory. However, the inclusion of participants at different career stages (from junior NPAPs and early career residents to more senior colleagues), allowed for a partial insight into these dynamics.

Third, the study focused exclusively on the perspectives of anaesthesia providers. While this offers an in-depth understanding of how professional identity is constructed within the profession, it does not capture how anaesthesia providers are perceived by other key actors in the field, such as surgeons, nurses, and hospital managers. Incorporating these perspectives would allow broadening the analysis from the anaesthesia field to the medical field, leading to a more comprehensive understanding of how anaesthesia professional identity is constructed and negotiated. However, given the shortage of literature in this field, this was the logical starting point.

Fourth, the study included a limited number of facilities (one hospital per country) which may constrain the generalisability of the findings. Although the selection aimed to capture variation across contexts, the results should be interpreted as illustrative rather than representative of all anaesthesia providers within each setting.

Future research should build on these findings by incorporating multi-perspective approaches that include other key actors within the healthcare system. Including these perspectives would enable a more comprehensive understanding of how anaesthesia providers are perceived and how symbolic capital is constructed and negotiated.

Conclusion

This study provides a novel and structurally grounded understanding of how professional identity is constructed and negotiated within anaesthesia. By applying Bourdieu's theory of practice, it highlights that anaesthesia providers' professional identity is fundamentally shaped by the dynamic interplay between habitus, capital, and field. The findings reveal a persistent misalignment between the high levels of cultural

capital held by anaesthesia providers and their limited symbolic and economic capital, highlighting a structural tension between clinical responsibility and professional recognition.

Through the comparison of high- and low-income contexts, this study further shows how the development of the field influence these dynamics. While anaesthesia providers in both Italy and Malawi share core professional dispositions, their capacity to translate expertise into recognition and influence is shaped by context-specific structural conditions.

Overall, this study contributes to advance the conceptualisation of professional identity by demonstrating the value of a Bourdieusian approach in capturing the complex and context-specific interplay between habitus, capital and field. Strengthening the position of anaesthesia will require not only enhancing technical expertise, but also improving recognition, and fostering collective strategies to rebalance the distribution of capital within the field.

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