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MAINTAINING CARE UNDER PRESSURE: JOB DEMANDS AND RESOURCES IN HEALTHCARE

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Abstract

Healthcare professionals operate under substantial clinical, emotional, temporal, and organizational demands, yet less is known about how they experience these demands and mobilize resources to manage them. Drawing on the Job Demands–Resources model and Conservation of Resources theory, this qualitative study examined job demands and resources among healthcare professionals. Semi-structured interviews were conducted with 17 healthcare professionals in Slovenia and analysed using a hybrid deductive–inductive thematic approach. Two overarching themes emerged. First, strain was attributed not only to clinical work itself but particularly to organizational conditions that constrained care, including insufficient capacity, administrative burden, fragmented communication, unpredictability, and hierarchical constraints. Meaningful clinical work could remain satisfying even when effortful, whereas demands that obstructed professionals' ability to provide appropriate care were experienced as particularly taxing. Second, collegiality, supportive leadership, professional expertise, autonomy, organization, communication skills, and personal commitment helped participants manage demanding work. Resources often operated through compensation rather than by removing underlying demands, enabling professionals and teams to maintain patient care despite organizational deficiencies. The findings suggest that understanding healthcare work requires attention not only to the intensity of demands, but also to whether they facilitate or obstruct valued professional work and to how available resources are mobilized in response.

Keywords: *job demands–resources; conservation of resources; healthcare professionals; job demands, job resources, physicians.*

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1 INTRODUCTION

Healthcare professionals work in environments characterized by high emotional labour, time pressure, and long and irregular working hours (Horrocks & Pounder, 2006; Shanafelt et al., 2015). These conditions make healthcare an important context for understanding how employees sustain functioning under demanding conditions while protecting their own well-being. Although substantial research has examined burnout, job demands, and occupational stress in healthcare (Shapiro et al., 2019; Shanafelt et al., 2015), with high physician burnout globally (West et al., 2018), while less is known about how healthcare professionals themselves understand the interplay between the demands they face, the resources they mobilize to manage them, and the ways in which they recover outside work. Existing perspectives provide important but often separate pieces of this process. The Job Demands–Resources model (JD-R; Bakker & Demerouti, 2007, 2017) explains how demanding working conditions consume energy and how job and personal resources support motivation and coping. Conservation of Resources theory similarly emphasizes the importance of protecting and replenishing valued resources under conditions of stress (Hobfoll, 1989, 2001).

This study examines job demands and resources through semi-structured interviews with 17 healthcare professionals in Slovenia. Rather than focusing only on whether particular demands or resources are present, we explore how professionals experience demanding working conditions and what enables them to manage these demands and continue providing care under pressure. Healthcare offers a particularly informative context because substantial temporal, emotional, relational, and organizational demands coexist with responsibility for providing appropriate patient care (Broetje et al., 2020). We extend the JD–R perspective by showing, first, that the experienced cost of demands may depend not only on the effort they require but also on whether they support or obstruct valued professional work and, second, that resources may sustain functioning by enabling professionals to compensate for organizational demands that remain unresolved.

2 BACKGROUND AND RESEARCH QUESTIONS

Healthcare work exposes professionals to substantial and often coexisting demands (Horrocks & Pounder, 2006; Shanafelt et al., 2015), including workload, time pressure, emotional encounters, irregular working hours, and organizational constraints. The JD-R model (Bakker & Demerouti, 2007, 2017) provides a useful framework for understanding how such working conditions shape employee functioning. Job demands are aspects of work that require sustained physical or psychological effort and are therefore associated with energetic costs, whereas job resources help employees achieve work goals, cope with demands, and maintain motivation. Furthermore, demands are also known to be appraised subjectively; the same working condition can be experienced as more or less taxing depending on how it is interpreted (Lazarus & Folkman, 1984), which is part of the rationale for a qualitative approach to this first question. Understanding which demands healthcare professionals themselves experience as most taxing is therefore an important first step.

Research question 1 (RQ1): What job demands do healthcare professionals perceive as most taxing in their work?

The JD-R model further proposes that resources can buffer the costs of demanding work and support continued functioning. These may include organizational and social resources, such as autonomy, leadership, and collegial support, as well as individual capacities: personal resources such as self-efficacy, optimism, and resilience; that help employees manage demanding situations (Xanthopoulou et al., 2007). COR theory (Hobfoll, 1989) complements this perspective by proposing that individuals strive to acquire, protect, and maintain valued resources, and that stress becomes particularly likely when resources are threatened, lost, or insufficient to meet demands. This means that coping with demanding healthcare work depends not only on the demands employees encounter but also on the resources they can mobilize in response.

RQ2: What job and personal resources do healthcare professionals draw on to manage their job demands?

3 METHOD

3.1 Participants and procedure

We conducted a qualitative interview study with 17 healthcare professionals working in Slovenia. Participants represented a range of professional and clinical backgrounds, mostly physicians, working in Paediatric Clinic of University Medical Center Ljubljana, and a few registered nurses working across paediatrics, psychiatry, immunology, haematology, nephrology, ophthalmology, urology, dialysis, emergency medical services, operating-room nursing, and healthcare management. Participants ranged in age from 37 to 59 years and had approximately 5 to more than 40 years of professional experience. Most worked full-time, and many regularly worked night shifts, on-call duties, or other irregular working hours. Participant characteristics are presented in Supplementary material 1.

Participants were recruited from two previous research studies examining sleep and work-related outcomes: one involving physicians and another involving nurses. Individuals who had participated in these studies and had consented to being contacted for future research were invited by email to take part in the interviews. To broaden the sample, par-

ticipants were also encouraged to share the invitation with eligible colleagues. Ethical approval was obtained from the Institutional Review Board of the University of Ljubljana (ethical clearance no. 3-2020) and the Medical Ethics Commission of the Republic of Slovenia (approval no. 0120-560/2023/3).

3.2 Data collection

Data were collected through semi-structured interviews conducted in Slovenian; they were done between autumn of 2025 and spring of 2026 by two interviewers. Each interview lasted about 50 minutes.

The interview guide focused on four broad areas: (1) job demands and situations participants experienced as particularly taxing; (2) job and personal resources used to manage these demands; (3) recovery experiences and activities outside work; and (4) experiences of exhaustion and sustainable functioning. The present study focuses specifically on job demands and resources; data concerning recovery and exhaustion fall outside the scope of this article and are therefore not reported here. Background questions covered participants' professional role, work experience, working hours, and night or on-call work. The semi-structured format allowed the interviewer to probe participants' responses and pursue issues that emerged during the conversation. Interviews were audio-recorded with participants' consent, transcribed verbatim, and anonymized prior to analysis. Quotations reported in the article were translated from Slovenian into English.

3.3 Data analysis

We analysed the interviews using a hybrid deductive–inductive thematic approach (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006; Pearson et al., 2025). Initial coding was informed by the Job Demands–Resources framework, reflecting the study's focus on job demands, and job and personal resources. At the same time, the coding remained open to patterns not captured by these theoretical categories.

Transcripts were coded at the level of meaningful segments. During analysis, related codes were compared across participants, refined, and grouped into broader themes. Inductively emerging patterns included, among others, organizational constraints that interfered with patient care, support from partners and family, professional psychological support, and the compensatory effort through which healthcare professionals maintained functioning despite organizational deficiencies. The analysis identified two overarching themes: (1) work demands that undermine sustainable clinical practice and (2) resources that make demanding work manageable. Each theme comprised four interrelated subthemes. The first theme included: (1a) organizational conditions that prevented participants from providing the care they considered necessary; (1b) administrative and non-clinical work; (1c) time pressure and unpredictability; and (1d) the psychological toll of patient care. The second theme comprised: (2a) collegiality and teamwork; (2b) supportive leadership, where present; (2c) work-related skills and capacities, including expertise, experience, personal organization, and autonomy; and (2d) broader personal resources, such as optimism, persistence, and patience. The two themes in Supplementary material 2 provide the analytic codes, coding criteria, and illustrative examples.

To support analytic credibility, themes were repeatedly checked against the original transcripts, including cases that did not conform to the dominant pattern. Illustrative quotations were selected to demonstrate the connection between participants' accounts and the resulting interpretations.

4 FINDINGS

4.1 When the Conditions of Care Become a Demand

Participants described healthcare work as demanding across multiple domains: high workload, time pressure, unpredictable clinical situations, emotionally difficult encounters, administrative responsibilities, and long or irregular hours.

However, a consistent distinction organized their accounts. For most, clinical complexity was not the most taxing aspect of the work in itself. Strain arose from the conditions under which clinical work had to be performed; being unable to provide the care one knows is needed.

4.1.1 "Nowhere further to send them": constrained care and helplessness in care

The strain participants described most vividly was not effort but helplessness: knowing what patients required and being unable to provide it because capacity, staffing, or organizational support was missing. At the tertiary level, where the study was carried out, this is presented as a structural problem; where expectations accumulate at the final referral point while resources do not grow to match them. The volume of patients grows, but there is nowhere to refer them further.

"There is a shortage of capacity everywhere. Because we are effectively the final referral point in Slovenia, everything flows towards us … at our level there is nowhere further to send many patients, so we try to resolve the issue, and expectations and demands continue to grow. The number of doctors does not grow in parallel … At present that is what troubles me most — not contact with the patients." (Interview 3)

The same experience appeared at the cost of the individual schedule. One participant working in child psychiatry described new patients requiring intensive, frequent treatment arriving when the existing schedule was already full, creating a sense of helplessness and disappointment, because the needs of patients exceed her capacities:

"When new, demanding patients arrive and require intensive care, I may have nowhere to place them in my schedule because it is already full. […] In my field you cannot simply see a child once and schedule the next appointment three months later." (Interview 2)

Furthermore, administrative and institutional requirements, such as the requirements from the insurers, could directly conflict with the clinical process itself:

"After examining and interviewing patients, you have to wait for test results. Some arrive quickly and others take much longer. The insurer expects an opinion immediately. […] The insurer may expect a patient to receive a discharge report within two days, but that is not always possible. At that point, all you could write is that the patient was here." (Interview 3)

These accounts define a qualitatively different strain from ordinary workload. Participants were required either to invest additional personal effort to bridge the gap or to accept that care could not be provided as they considered optimal. In the interviews this appeared as frustration and helplessness where professional standards collided with organizational constraints; its theoretical reading, in relation to moral distress, is developed in the Discussion.

4.1.2 When the organization gets in the way of care, and the tasks take time away from patients

A second pattern concerned work generated by the organization surrounding care: administration, inefficient procedures, short deadlines, often required by the institutions or insurers, poor information flows, and logistical tasks participants, for which participants did not regard as part of their professional role. The burden depended less on volume than on perceived purpose — work that visibly served patients was tolerated, while work that served only procedure was described as disproportionately draining:

"When you help someone, you receive positive feedback and become less tired than when performing work that exists only for its own sake. The latter is much more exhausting." (Interview 3)

"Administrative tasks eat the time meant for patients." (Interview 11)

"Working with patients and parents, and the physical work, do not bother me at all. What burdens me is being unable to obtain library access, having to deal with payments that the organisation should arrange, and having to organise resources myself. […] I like working with patients and I also like writing, but this administrative burden truly drains me." (Interview 12)

Gaps in organizational support left clinicians personally responsible for making the system work. One participant argued that functional support services would free time "*to think about patients and work directly with them*" (Interview 11); another described the compensatory effort in the starkest terms:

"Sometimes you feel that there are no background mechanisms or support systems functioning, so you truly have to do everything yourself. You have to arrange everything for each patient as though you were arranging it for your own family member; otherwise it simply does not happen." (Interview 10)

Organizational communication itself also generated pressure. One participant described receiving a complex request only days before its deadline although it had circulated through the institution for weeks. That is pressure they explicitly characterized as organizational rather than intrinsic to the task.

Moreover, vertical organizational structures could generate similar pressure. Participants contrasted strong cooperation within their immediate teams with more difficult communication across hierarchical levels: "*/.../ this team really cooperates incredibly well with each other on some horizontal level, right. But the problem always appeared on the vertical level, so superiors - subordinates.*" (Interview 7). Long communication chains, limited transparency, and decisions made further from clinical work were described as sources of stress and, at times, as constraints on autonomy. As one participant explained that "*communication from supervisors does not always reach me directly. It goes through a chain, and that is a source of stress*" (Interview 2).

These processes were not always transparent and appeared to leave limited room for physicians to participate in decision-making, which could also reduce their sense of autonomy. As one participant explained, *"I may also have a different idea about how something should be handled than my supervisor, and at times I feel that I do not have full autonomy. I would prefer something more democratic and more autonomy for individuals, although I also understand that managing a large institution is difficult"* (Interview 2).

These tensions did not appear to reflect leadership behaviour alone. Supervisors themselves operated within staffing shortages, financial constraints, and pressures from higher organizational levels, which could then be transmitted downwards. The pressure to retain staff while simultaneously addressing performance issues created a difficult balancing act, potentially placing supervisors themselves in a position between organizational demands from above and the needs of employees below. In this sense, vertical tensions may reflect not only shortcomings in leadership but also the broader structural constraints within which leadership is exercised.

One participant in a leadership position described the difficulty of simultaneously asking employees to sustain performance while knowing how stretched they already were:

"In some way you are constantly asking people to hold on and work well. At the same time, it is difficult to demand that they perform optimally. It is a kind of double-edged sword." (Interview 8).

Vertical strain therefore appeared partly embedded in the organizational conditions within which leadership was exercised.

4.1.3 Time pressure, unpredictability, and the schedule

Workload was experienced as most taxing when demands were concurrent, unpredictable, and difficult to defer, not simply numerous. Emergency work was demanding precisely because it arrived without structure alongside established obligations:

"Lack of time, especially because of emergency cases. They are unpredictable and arrive without structure, so you do not know where to begin, what to do, or whether you will manage everything." (Interview 9)

Exhaustion was typically produced by accumulation across domains rather than by any single task:

"When your batteries are already low, difficult patients arrive and you make a major effort. Even if everything goes well, additional demands then appear from entirely different areas. Exhaustion results when demands from several domains accumulate at once. […] You have already invested great effort in a difficult case, and then another unrelated requirement appears." (Interview 3)

As another participant put it, no single activity stood out; "*when there is a lot of everything, it becomes more demanding*." For those working night shifts and on-call duties, the temporal organization

of work was a demand in its own right: long duty periods extended into the following day, and interrupted sleep removed the recovery that the schedule presupposed.

"During on-call nights, you are woken several times by the telephone, and sometimes you have to go in. […] The last time, I was still working until half past midnight, was woken again at half past one, and had an admission at four. I fell asleep sometime between half past five and six, and after that I could not sleep again. […] On average, I would say you are woken about three times a night." (Interview 6)

One physician described weekday on-call work effectively producing a 36-hour working period; another emphasized that sustainability required not time off in general but sufficient recovery between duties and the possibility of going home after them.

4.1.4 The psychological toll of patient care

While organizational and temporal pressures were the most widely shared demands, clinical and relational strain remained substantial and varied across contexts. Some participants named dying patients, palliative care, unsuccessful treatment, or conversations with parents about serious illness as the most exhausting parts of their work. In paediatric settings, a specific relational configuration appeared: the patient is the child, but the communicative counterpart is often the parent, whose fear, expectations, adherence, and independently gathered information all require management:

"You treat the child, but at the same time you have to persuade the parent to administer medication […] Parents are naturally worried about their children […] A great deal of explanation is required." (Interview 3)

For some clinicians, this relational work also involved deliberate emotional investment. Rather than distancing themselves from patients and families, they described building trust and connection as integral to providing good care, while recognizing that doing so could be personally depleting:

"I invest considerable energy in creating trust and connecting with the patient and family. I try to establish good contact because I believe it leads to better care. I do not protect myself by depersonalising the patient. […] That approach uses more emotion and can therefore leave you somewhat more depleted." (Interview 3)

Another participant similarly found interactions with parents somewhat more demanding than work with children themselves. Where treatment depended on parental follow-through, inability to secure it produced the same helplessness described in Section 4.1.1: the physician knows the appropriate course of action but cannot enact it without the cooperation of a third party. One participant explained:

"Situations involving poor compliance, especially from parents, are demanding because treatment does not progress as we would like, and I sometimes feel powerless. In our field it is not enough simply to give medication; certain patterns also have to change and the family has to follow our recommendations. […] That produces a sense of helplessness." (Interview 2)

The demands experienced as most taxing were rarely reducible to a single task. Meaningful clinical work could remain satisfying even when effortful; strain intensified when surrounding conditions fragmented it, obstructed it, or prevented professionals from providing care as they believed it should be provided.

4.2 Resources that make demanding work manageable

Against these demands, participants identified resources at both the workplace and individual level. Their accounts had a clear centre of gravity: the immediate social environment first, followed by professional capability and personal disposition.

4.2.1 "I am not alone": collegiality and teamwork

Collegial support was consistently highlighted as a critical resource, providing both emotional and psychological relief in demanding situations. Participants valued having colleagues with whom they could discuss difficult experiences, share frustrations, and recognise that others were facing similar challenges. As one participant explained:

"The key is the team that supports you. […] The close colleagues you work with, who can help you, relieve you of some of the workload, and also provide psychological relief through conversation." (Interview 14)

This sense of shared experience appeared particularly important because colleagues understood the specific realities of healthcare work in ways that people outside the profession often could not. One participant noted that *"someone outside the field can listen and empathise, but they understand it differently. Relationships within the team are therefore crucial"* (Interview 3). Patient confidentiality further limited the extent to which clinicians could discuss particular cases with family members at home. Informal interactions at work therefore became an important outlet: *"We can talk, have something to eat together, and recognise that we face similar problems. Sometimes you receive useful advice"* (Interview 2). Another participant similarly described colleagues as *"a big part of why you say you like going to work"*, because even when work was difficult, *"you can discuss it, you can have a laugh"*, which *"takes a lot of the burden off"* (Interview 1).

Support was also highly practical. Rather than being limited to encouragement, collegiality was enacted through everyday task redistribution and mutual assistance when workload became uneven. Participants described colleagues stepping in, covering work, and actively noticing when somebody was struggling: *"We also genuinely help one another. Today, for example, I had quite a lot to do and colleagues offered to take over some tasks. […] If we see that somebody has too much work, we offer help."* (Interview 6). In this way, teamwork directly reduced the amount of work an individual had to carry.

Finally, colleagues served as an important source of knowledge and professional reassurance. Difficult or uncertain situations could be discussed with others who possessed relevant experience, allowing clinicians to seek advice, compare interpretations, and work towards solutions together. Collegiality therefore reduced demands in several ways at once: colleagues could redistribute the practical workload, help make sense of difficult clinical situations, and share the emotional burden of dealing with them. The recurring message across interviews was not simply that colleagues made work more pleasant, but that a supportive team made demanding work feel more manageable because professionals did not have to carry it alone.

4.2.2 Superiors and leadership

Although vertical relationships could themselves become a source of strain, participants' accounts also showed that leadership could function as an important resource when supervisors were accessible, responsive, and understood the realities of the work. Supportive leaders provided reassurance, participated in problem-solving, and created a sense that difficult situations did not have to be managed individually.

"Co-workers are also good support. The manager too, she is really great." (Interview 7)

"If someone has a problem, they share it with the rest of the team, and we work towards a solution together. Even when something does not require an immediate solution, it helps to have understanding from the team and the head of department." (Interview 10)

The same participant valued a head of department who "*always has an open door—literally*"; another described both co-workers and their manager as important sources of support. Across different accounts, what appeared to matter was not simply the formal presence of a supervisor, but accessibility, responsiveness, and willingness to engage with employees' problems.

Leadership therefore occupied a distinctive position in participants' accounts: depending on how vertical relationships were experienced, it could either add to existing organizational demands or provide a resource for managing them.

4.2.3 Expertise, experience, organization, and autonomy

The conversations with colleagues through which difficult cases were discussed (Section 4.2.1) also contributed to the development of professional judgment. Accumulated knowledge and experience

formed another consistently named resource, primarily by reducing uncertainty and increasing confidence in demanding situations:

"Professional knowledge makes it easier to be confident. Experience also matters. Over the years, the work has become less demanding for me." (Interview 9)

At the same time, participants emphasized that expertise required continued learning rather than simply accumulated experience: *"You must keep learning. New things constantly arise and can always surprise you. […] Confidence is useful, but believing you know absolutely everything is not good. I am always curious about something, and that helps me."* (Interview 12)

Personal organization, prioritization, and strategic problem-solving similarly helped participants manage competing demands by identifying what required immediate attention and what could be deferred. One participant described good organization as a central resource, while acknowledging that it could not fully compensate for excessive workload (Interview 7):

"I would say good personal organization is an important characteristic. I prioritize tasks by difficulty, doing the harder ones first […] while less urgent things can be postponed to the next day, so that the urgent things are always done." (Interview 7)

Another participant similarly emphasized a strategic orientation towards demanding situations: *"Maybe such […] a more strategic approach, that every situation doesn't immediately throw you off, that maybe you see some solutions sooner. Or maybe that you know how to set priorities, what is urgent, what isn't so urgent."* (Interview 14)

Communication skills served a similar function in relationally demanding work, helping participants listen, explain clearly, establish trust, and prevent escalation. As one participant noted, *"Communication therefore requires experience, while expectations continue to rise. [Parents] request more and more detail and sometimes know a great deal about the specific issue they have researched ..."* (Interview 3)

Finally, participants valued autonomy—the discretion to organize and approach their work in ways they considered appropriate. Where autonomy was constrained by hierarchical structures, its absence was experienced as an additional source of strain (as presented in Section 4.1.2) rather than a neutral condition. Expertise, organization, communication, and autonomy therefore shared a common function: they increased participants' capacity to navigate demanding situations and retain a sense of control, even when they did not remove the demands themselves.

4.2.4 Personal resources

Beyond the skills and capacities that helped participants manage work directly, a further set of resources concerned how they approached demanding situations more generally. Participants consistently mentioned persistence, patience, and a positive or optimistic outlook.

A positive perspective helped participants manage difficult periods by focusing on the possibility that circumstances would improve or eventually pass. As one interviewee explained: *"Don't think about how bad you have it now in this situation. Think about how good you'll have it in another situation."* (Interview 16)

An optimistic outlook was also described as a broader orientation towards both other people and challenging situations. One interviewee reflected: *"I think of myself that I am actually a very big optimist and [...] mostly I think well of people until they really do something bad to me […] I am simply friendly, so it seems to me that mostly then you also get good back."* (Interview 1)

Beyond optimism and persistence, interviewees identified responsibility towards work, a strong work ethic, and commitment to providing good care as additional personal resources. One participant emphasized:

"If doing the work well is an important value to you, that helps ensure that it is completed properly." (Interview 2)

Similarly, another participant highlighted personal standards and commitment: *"What matters to me is knowing that I gave everything I reasonably*

could" (Interview 3). Successful treatment, visible improvement, and helping patients were likewise described as sources of motivation and energy.

For some participants, a strong work ethic was also connected to accepting that demanding periods were part of the job and reminding themselves that these periods were temporary:

"Partly simply knowing that the work has to be done—perhaps work ethic. It also helps to know that it will end, that the difficult period is limited to that day and that at four o'clock I will go home." (Interview 9)

Overall, these accounts suggest that personal resources extended beyond individual optimism or resilience. Persistence, responsibility, work ethic, and commitment shaped how participants interpreted and endured demanding periods, helping them sustain motivation and commitment to providing good care.

5 DISCUSSION

5.1 Findings & theoretical contributions

This study examined how healthcare professionals experience job demands and use resources to manage them while continuing to provide care under pressure. A central finding was that the most taxing demands were not necessarily those requiring the greatest clinical effort. Participants often described complex patient care as meaningful despite its intensity. Strain became particularly pronounced when organizational conditions (including insufficient capacity, administrative burden, fragmented communication, limited support, unpredictability, and hierarchical constraints) interfered with their ability to provide care as they believed it should be provided. At the same time, colleagues, supportive leaders, professional expertise, autonomy, organizational and communication skills, and personal commitment helped participants manage these conditions.

First, these findings extend the JD–R understanding of job demands by highlighting that their perceived cost may depend not only on the effort they require, but rather on whether that effort contributes to or obstructs valued professional work. This is consistent with research showing that employees' appraisals shape how demands are experienced (Podsakoff et al., 2023). In our study, demanding clinical encounters could remain meaningful, whereas organizational tasks and constraints that diverted time from patients or prevented appropriate care were experienced as particularly draining. This resonates with research on illegitimate tasks (Semmer et al., 2015) and moral distress in healthcare (Lamiani et al., 2017): participants repeatedly described helplessness when they knew what appropriate care required but organizational conditions prevented them from delivering it. In healthcare, where professional work is closely tied to responsibility for patient care, understanding job demands may therefore require attention not only to their intensity, but also to whether they facilitate or obstruct that core professional purpose.

Second, the findings extend the understanding of job and personal resources by drawing attention to how resources are used in relation to demands. Consistent with JD–R and COR theory, participants drew on a range of job and personal resources—including social support, autonomy, expertise, supportive leadership, and personal strengths—to manage demanding work (Bakker et al., 2023; Hobfoll, 1989, 2001). However, in this study resources frequently operated through compensation rather than by removing the underlying demand. From a COR perspective, this compensatory pattern can be understood as resource investment: when organizational resources were insufficient, professionals drew on other available resources—such as time, effort, expertise, and social support—to compensate and maintain functioning. Colleagues redistributed excessive workloads, experienced professionals helped solve problems created by organizational deficiencies, and committed employees invested additional effort to maintain standards of care. Leadership illustrated this dynamic particularly clearly: accessible and responsive supervisors could provide an important resource, whereas opaque communication, restricted autonomy, and pressures transmitted through the hierarchy could themselves become demands. Moreover, leaders were themselves constrained by staffing shortages and pressures from higher organizational levels. These findings therefore suggest that the role of a resource cannot always be understood independently of the demands and organizational conditions within which it is mobilized.

5.2 Practical implications

The findings suggest that healthcare organizations should focus not only on strengthening individual resources, but also on reducing avoidable organizational demands. Adequate staffing and administrative support, transparent communication, greater involvement in decision-making, sufficient autonomy, and accessible and responsive leadership may help professionals devote more of their resources to patient care rather than compensating for system deficiencies. At the individual and team level, maintaining collegial support, sharing workload when possible, and using prioritization and problem-solving strategies may further help professionals manage demanding periods without carrying these demands alone.

5.3 Limitations and future research

Several limitations should be considered. The qualitative design and relatively small Slovenian sample limit statistical generalizability, although the diversity of professional backgrounds provided variation in experiences. The findings reflect participants' subjective interpretations rather than objective measures of workload, resources, recovery, or exhaustion. Additionally, the interviews were conducted by two researchers, which may have introduced some variability in interviewing style, follow-up questions, and the depth with which particular topics were explored.

Moreover, the cross-sectional interview design cannot establish temporal or causal relationships between compensation, recovery, and exhaustion. Future research could examine longitudinally how healthcare professionals mobilize resources in response to changing demands, particularly whether resources reduce demands or instead enable continued compensation for unresolved organizational deficiencies, and what organizational conditions shape these processes.

6 CONCLUSION

Healthcare professionals in this study were often able to maintain effective functioning under substantial pressure because they possessed strong professional, social, and personal resources. However, those same resources were frequently used to compensate for organizational deficiencies. The findings therefore suggest that sustainable functioning depends not simply on possessing sufficient resources, but on whether those resources enable employees to manage demands while preserving the opportunity to recover.

EXTENDED SUMMARY/IZVLEČEK

Zdravstveni delavci se pri svojem delu srečujejo z visokimi delovnimi zahtevami: časovnimi pritiski, omejitvami, ki izhajajo iz organizacije dela, čustvenimi obremenitvami in obremenitvami, ki izhajajo iz odnosov pri delu. Namen raziskave je bil preučiti, katere delovne zahteve sami doživljajo kot najbolj obremenjujoče ter katere delovne in osebne vire uporabljajo za njihovo obvladovanje. V raziskavi je sodelovalo 17 zdravstvenih delavcev v Sloveniji, podatki pa so bili zbrani s polstrukturiranimi intervjuji in analizirani s kombiniranim deduktivno-induktivnim pristopom tematske analize.

Ugotovitve kažejo, da najzahtevnejši vidiki dela niso bili nujno tisti, ki so zahtevali največ kliničnega napora. Delo s pacienti je bilo lahko za njih sicer zelo intenzivno, vendar so v njem našli pomen in smisel. Obremenitev se je povečala predvsem takrat, ko so organizacijske okoliščine ovirale zagotavljanje ustrezne oskrbe pacientov. Med ključnimi zahtevami so bili pomanjkanje kapacitet, administrativne in logistične obveznosti, neučinkoviti procesi, slaba komunikacija, omejena avtonomija, časovni pritisk, nepredvidljivost ter dolgi in neredni delovniki. Posebej izrazit je bil občutek nemoči, ko so zdravstveni delavci vedeli, kaj pacient potrebuje, vendar tega zaradi organizacijskih omejitev niso mogli zagotoviti.

Za obvladovanje zahtev so bili najpogosteje izpostavili sodelavce, ki jim zagotavljajo čustveno podporo, pomoč ter strokovni posvet. Pomembni viri so bili tudi strokovno vodstvo, znanje in izkušnje, organiziranost, komunikacijske spretnosti, avtonomija ter osebne značilnosti, kot so optimizem, vztrajnost, odgovornost in predanost delu. Vodenje je lahko predstavljalo tako vir podpore kot dodatno zahtevo, odvisno od dostopnosti vodij, transparentnosti komunikacije in širših organizacijskih pogojev.

Ugotovitve dopolnjujejo model delovnih zahtev in virov (JD–R) z ugotovitvijo, da obremenjujoč učinek zahtev ni odvisen le od potrebnega napora, temveč tudi od tega, ali zahteve podpirajo ali ovirajo delo, ki ga zdravniki doživljajo kot smiselnega in pomembnega. Hkrati lahko viri zaposlenim pomagajo predvsem tako, da jim omogočajo kompenzacijo organizacijskih pomanjkljivosti, ne da bi te pomanjkljivosti dejansko odpravili.

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DECLARATIONS

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request

Ethical approval: Research received clearance from the institutional review board of the University of Ljubljana (ethical clearance no. 3-2020) and the Medical Ethics Commission of the Republic of Slovenia (approval number 0120-560/2023/3).

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SUPPLEMENTARY MATERIALS

Supplementary file 1: Participants

Participants	Sex	Age	Professional role / clinical area	Professional experience	Night/shift/on-call work
P1	F	50	Physician; specialty not clearly recorded	22 years	Yes; ~2/month
P2	F	40	Physician; child and adolescent psychiatry	approx. 10 years	Yes; ~2/month
P3	M	48	Physician; allergology, rheumatology and clinical immunology	approx. 20 years	Yes; 2–3/month
P4	F	56	Registered nurse; haematology / transplant coordination	34 years	Yes; night and on-call work
P5	M	59	Emergency medical services; formerly ambulance/helicopter emergency care	41+ years	Formerly substantial shift/night work
P6	M	57	Physician; paediatrics, gastroenterology and hepatology	28 years	Yes; ~5/month
P7	F	28	Registered nurse; dialysis	approx. 5 years	Yes; shift/night work
P8	M	41	Registered nurse; nursing management	15 years	Yes; ~4/month
P9	F	38	Physician; child and adolescent psychiatry	approx. 10–11 years	Yes; 1–2/month + standby
P10	F	43	Physician; paediatrics	15 years	Yes; 2–3/month
P11	F	42	Physician; paediatrics	13 years	Yes; ~2/month
P12	F	58	Physician; paediatrics, primarily nephrology, with cardiology work	23.5 years	Yes; ~2/month
P13	F	44	Registered nurse; ophthalmology and quality management	20 years	No night work; some afternoon work
P14	F	44	Psychiatry; deputy professional leadership role	19 years	Yes; ~3/month
P15	F	55	Urology; professional role not explicitly stated in transcript	33 years	Currently no night work
P16	F	51	Registered nurse; operating-room nursing and quality management	30 years	Yes; ~5/month
P17	F	44	Physician; paediatrics / paediatric neurology	16 years	No current night/on-call work

Supplementary file 2: Themes, subthemes, coding criterion & illustrative examples

Theme	Subtheme	Coding criterion / included content	Illustrative example
1. Work demands that undermine sustainable clinical practice	Constrained care and helplessness	Accounts in which participants knew what care was needed but lacked sufficient capacity, staffing, time, organizational support, or referral options to provide it as intended.	"At our level there is nowhere further to send many patients, so we try to resolve the issue, and expectations and demands continue to grow." (P3)
	Administrative and non-clinical work	Administrative, procedural, logistical, or coordination work perceived as inefficient, outside the professional role, or taking time and energy away from patient care.	"I like working with patients and I also like writing, but this administrative burden truly drains me." (P12)
	Time pressure and unpredictability	Situations in which demands were simultaneous, unexpected, difficult to defer, or accumulated across unrelated areas of work.	"Emergency cases… are unpredictable and arrive without structure, so you do not know where to begin." (P9)
	Long and irregular working time	Night work, shift work, standby, on-call duties, extended working periods, interrupted sleep, and insufficient time between duties.	"During on-call nights, you are certainly woken several times by the telephone, and sometimes you have to go in." (P6)
	The psychological toll of patient care	Difficult diagnoses, treatment failure or uncertainty, dying or palliative patients, emotionally difficult conversations, demanding relatives, non-adherence, and management of parental fear or expectations.	"You treat the child, but at the same time you have to persuade the parent to administer medication." (P3)
2. Resources that make demanding work manageable	Collegiality and teamwork	Practical assistance, redistribution of work, covering absences, professional advice, shared problem-solving, emotional support, and discussion of difficult experiences.	"Professional knowledge—knowing what to do—and support from colleagues, both emotional support and practical help. Collegiality." (P9)
	Supportive leadership	Accessible, responsive, and understanding supervisors who facilitated problem-solving, supported employees, or buffered rather than intensified demands.	"It helps to have understanding from the team and the head of department." (P10)
	Professional knowledge and experience	Expertise, accumulated experience, confidence based on knowledge, continued learning, professional curiosity, and reduced uncertainty through experience.	"Professional knowledge makes it easier to be confident. Experience also matters." (P9)
	Organization, autonomy, and communication competence	Prioritizing and structuring work, deciding what could wait, discretion over how work was carried out, listening, explaining clearly, building trust, and managing interactions effectively.	"I can create space in which people feel heard." (P2)
	Responsibility, commitment, and work ethic	Conscientiousness, persistence, responsibility toward patients and work, commitment to standards, and motivation to complete work properly despite pressure.	"If doing the work well is an important value to you, that helps ensure that it is completed properly." (P2)
	Personality traits and mindset	Personal characteristics that help manage job demands, such as persistence, a high treshold for patience, and a positive, optimistic outlook.	"I just say: the glass is half full or half empty. I decide how I see it.[…] I try to think about positive things. […] that's how I am. But now simply this seems to me - I go through life more easily if I look positively." (P16)