

### **Abstract**

**Objective:** Despite increased risk of experiencing mental health concerns, particularly related to stress and burnout, psychological help-seeking among medical doctors is typically low. This study examined the barriers to treatment experienced by doctors for stress and burnout related difficulties. **Method:** A mixed-methods design was adopted. The quantitative sample comprised 274 Australian based medical doctors. Qualitative interviews were conducted with a sub-sample of 20 (11 regional and 9 metropolitan) doctors. For triangulation, five stakeholder interviews were also conducted with representatives of the profession. **Results:** Time was the greatest barrier to treatment. Qualitatively, doctors identified barriers such as stigma and fear of professional consequences, and particularly among regional doctors, access to services and professional culture. **Conclusions:** There is a need for tailored strategies to address barriers to psychological treatment among doctors, to improve service access and mental health.

## **What Prevents Doctors from Seeking Help for Stress and Burnout? A Mixed Methods Investigation among Metropolitan and Regional Based Australian Doctors**

### **1. Introduction**

The mental health of medical doctors is increasingly a focus of attention in research, medical, and public forums, with growing acknowledgement that mental health difficulties, particularly in relation to stress and burnout, are both highly prevalent key determinants of patient care (BLINDED, under review; Clode, 2004; Eelen et al., 2014; Elliot, Tan, & Norris, 2010; Johnston et al., 2016; Shanafelt et al., 2012). Within Australia, rates of burnout as high as 75% have been documented among junior doctors (Willcock, Daly, Tennant, & Allard, 2004); with high levels of stress found in 41% of senior doctors (Bruce, Sanger, Thomas, Petkus, & Yates, 2003). These conditions are associated with adverse outcomes for the doctor, patient, and healthcare service generally (Clough et al., 2017; Ireland et al., 2017). Research to date has identified an increased risk of: medical and decision-making errors; experiencing additional psychiatric disorders; poorer doctor-patient interactions; and absenteeism and early retirement (Clough et al., 2017; Jones et al., 1988; Shanafelt, Bradley, Wipf, & Back, 2002; West et al., 2006; Williams, Manwell, Konrad, & Linzer, 2007). Despite these troubling outcomes, psychological help-seeking among medical doctors remains low (Stanton & Randal, 2011). In a recent study, despite 18% of doctors being identified as depressed, only 2% of those actually obtained help (Canadian Medical Association, 2003). Evidence suggests that junior and young doctors may be the most vulnerable and the least likely to disclose mental health difficulties (Cohen, Winstanley, & Greene, 2016).

Similar to the general population, it is likely that doctors experience a range of barriers to accessing support for mental health concerns. A systematic review of 26 studies

relating to healthcare access and treatment barriers among doctors found qualitative support for the conclusion that systemic barriers, such as cultural issues and long working hours, had greater impact than individual barriers, such as embarrassment or cost, in inhibiting help-seeking behaviours (Kay, Mitchell, Clavarino, & Doust, 2008). However, a quantitative synthesis (e.g. meta-analysis) of the relative importance of these barriers was not conducted and conclusions about the relative importance of various barriers remains preliminary until qualitative data can be corroborated with statistical comparisons. The review also identified that despite the volume of expert opinion in the field, claims are currently supported by a paucity and poor quality of data (Kay et al., 2008). Evidence from this review is now a decade old and since its publication, additional studies have focused on singular aspects of barriers to help-seeking among doctors, for example, attitudes (Cohen et al., 2016). A recent study conducted among female, parent medical practitioners in the United States identified an array of barriers to treatment for mental health concerns, including time, fear of professional consequences, stigma, and a belief that one could or should manage mental health problems independently (Gold, Andrew, Goldman, & Schwenk, 2016). However, the extent to which these results can generalise beyond the specific gender and caregiving population sampled is unclear. In addition, the primarily qualitative approach taken to understanding barriers did not investigate the relative importance of each barrier to preventing help-seeking.

Within the broader literature doctors are also typically treated as a homogenous group with little attention paid to understanding contextual factors such as the regional context in which doctors work (Elliot et al., 2010). Doctors working in regional areas experience unique occupational stressors when compared to their metropolitan counterparts (BLINDED, under review; Larkins & Evans, 2014). Practitioners in these areas may therefore require greater tailoring of interventions to overcome greater or potentially unique barriers to healthcare access. However, no such examination of barriers to healthcare for mental health concerns

has been conducted in the Australian context. Such knowledge is critical to understanding the healthcare needs of this population and to for the development of tailored evidence-based strategies to assist doctors in overcoming potential barriers to healthcare access.

Examining the barriers that prevent doctors from seeking help for psychological distress is critical to mitigating the potentially devastating effects mental ill health has on this population; this is also concerning given the knock-on effects of these issues for patient care. The current study adopted a mixed-methods approach, using qualitative and quantitative research strategies, to examine barriers to healthcare access for stress and burnout among doctors working in regional and metropolitan-locations in Australia. It was predicted that doctors practising in regional locations would report unique and greater barriers to healthcare access when compared to doctors practising in metropolitan locations.

## 2. Method

### 2.1. Participants

**2.1.1. Quantitative sample.** Participants were 274 Australian-based medical doctors. Demographic details are displayed in Table 1. For the 233 doctors who provided valid postcodes, regional status was coded according to the Australian Statistical Geography Standard – Remoteness Structure (ASGS-RS). This scheme classifies Australian locations into classes of remoteness based on access to services.

**2.1.2. Qualitative sample.** The qualitative sample comprised 11 regional and 9 metropolitan based doctors (Table 1). To further triangulate the issues discussed, five stakeholder participants were included. These participants represented the Australian Medical Association (AMA), the Doctors' Health Advisory Service (DHAS), hospital-based medical education, and practice management (one regional and one metropolitan).

### 2.2. Design

Both the quantitative and qualitative components formed part of a larger data collection program, with the overall focus of the broader study being on doctors' wellbeing, work environment, and treatment access. The present study adopted a mixed methods design, with the first sample of participants completing several quantitative self-report measures and the second sample completing a qualitative semi-structured interview.

### **2.3. Materials**

**2.3.1. Barriers to healthcare access.** Barriers to healthcare access for the treatment of stress or burnout was measured using an adapted Perceived Barriers to Psychological Treatment (PBPT) scale (Mohr et al., 2010). The PBPT is a self-report scale that addresses factors that may interfere with an individual receiving weekly psychological treatment. The construct validity of the PBPT has been assessed using exploratory and confirmatory factor analyses.

The PBPT has eight subscales, with all subscales demonstrating strong internal consistency in the present study: stigma ( $\alpha = .89$ , items relating to perceived discomfort with the perceived negative meaning of accessing services, as well as fear of judgment from self or others), lack of motivation ( $\alpha = .90$ , items relating to general and therapy focussed pursuit of goals), emotional concerns ( $\alpha = .80$ , items relating to undesirable emotional states expected to arise in or from therapy), negative evaluation of therapy ( $\alpha = .81$ , items related to perceived lack of helpfulness or harm resulting from therapy), misfit of therapy to needs ( $\alpha = .77$ , items relating to therapy being an unjustifiable luxury or that one's problems are poorly suited to therapy), time constraints ( $\alpha = .76$ , items reflecting competing activities or demands), participation restrictions ( $\alpha = .83$ , items relating to physical and transportation difficulties in attending therapy) and availability of services ( $\alpha = .63$ , items related to difficulties finding available therapy options) (Mohr et al., 2010). All subscales (see Table 2), along with a total summed scale score ( $\alpha = .92$ ), were included in the present study.

Instructions for the PBPT were altered to reflect barriers to accessing support specifically for difficulties with stress or burnout. Furthermore, to encompass a greater range of support options available to individuals (rather than simply psychological treatment), participants were instructed that items related to accessing formal assistance, which included professional sources such as psychologists, psychiatrists, general practitioners, and counsellors, but did not include informal sources such as friends, colleagues, relatives, or pastoral care.

**2.3.2. Interview schedule.** A schedule of semi-structured, open-ended questions was created by the first, second, and fourth authors. Questions were created based on previous literature and driven by a desire for needs analysis as to what strategies may be needed to promote help-seeking among doctors. As this study formed part of a larger project, the complete interview schedule is available from the authors upon request. However, for the current study, qualitative data was drawn from responses to open ended questions relating to factors that may prevent or delay doctors from seeking help, perceived treatment (positive or negative) within organisations and the profession of doctors experiencing stress or burnout, and discussion of intervention engagement strategies. Doctors reported on their perceptions of access to services and factors that may impede this access. Stakeholders were asked to report on their perceptions of these factors for doctors as a profession, as opposed to their own personal experience.

## **2.4. Procedure**

Ethical approval for the study was granted by the associated university's ethics committee. Participants were recruited through posts placed on social media forums and groups, advertisements placed in medical journals and newsletters, and through snowball sampling. Quantitative measures were delivered by means of an online questionnaire (using Qualtrics survey platform), with participants given the option to then participate in the

qualitative interview component. Semi-structured, individual interviews were conducted until saturation was reached for each group (regional and metropolitan). Stakeholder participants were recruited separately, through interview requests with relevant organisations. The qualitative component of the study was designed and administered in accordance with COREQ guidelines (Tong, Sainsbury, & Craig, 2007). The interviews were conducted (mean length = 45.63 minutes) either in person or via the telephone (depending on location and participant preference), with interviews audio-recorded, transcribed verbatim with interview notes, and member checks conducted. Transcripts were coded according to Braun and Clarke's (2006) guidelines for thematic analysis, with interview content coded, grouped into larger themes, and these themes then defined and reported. Approximately 40% of interviews were double coded by a second independent coder (with results compared and agreement reached) to improve accuracy and consistency. Quantitative data were screened and tested for analysis assumptions, with missing data handled by listwise deletion per analysis.

### 3. Results

#### 3.1. Quantitative Investigation of Barriers

For the sample as a whole, a within-subjects one-way ANOVA showed significant differences in the mean ratings across the eight barriers,  $F(5.25, 870.64) = 61.95, p < .001$ . Table 2 displays the descriptive statistics and rankings of each type of barrier separately for each subsample. Regarding the relative strength of these barriers for the full sample, follow-up comparisons with Bonferroni correction ( $\alpha/n$  comparisons) showed that time was rated as the strongest barrier (Bonferroni  $ps < .001, ds = 0.70$  [availability] to 1.20 [participation barriers]), while participation barriers were rated as the weakest barrier (Bonferroni  $ps < .001, ds = -0.32$  [emotional concerns] to  $-0.69$  [availability]). Emotional concerns were rated as a significantly weaker barrier when compared with all other barriers except for motivation

(Bonferroni  $ps < .05$ ,  $ds = -0.26$  [misfit of services] to  $-0.43$  [stigma]). Finally, motivation was rated as a weaker barrier than availability of services (Bonferroni  $p < .05$ ,  $d = -0.20$ ).

Sample sizes for doctors from remote, very remote, and outer regional areas categories were too small to allow for meaningful inferences about population differences. Therefore, these locations were combined into a composite "outer regional/ remote" (hereon called OR/ remote) category). The three location-based sub-samples (metropolitan, inner regional, OR/ remote) did not differ significantly in gender, number of hours worked per week, and number of years as a doctor ( $ps > .05$ ). From the original full sample 274, 165 (60.22%, metropolitan  $n = 111$ , inner regional  $n = 28$ , OR/ remote  $n = 26$ ) provided complete data on both the PBPT and geographical work location and were included in the analyses.

Between-subjects ANOVAs revealed no significant differences in mean ratings of barriers to treatment except for Availability of Services, ( $F(2, 165) = 3.08$ ,  $p < .05$ ). This main effect was followed up with post hoc pairwise comparisons with Bonferroni correction. Results showed that participants in OR/ rural areas reported significantly greater barriers regarding the availability of services than participants in metropolitan areas ( $p < .05$ ,  $d = .52$ ).

Mixed model ANOVA revealed a significant two-way interaction between sample location (between subjects factor) and barrier rating (within subjects factor),  $F(10.47, 847.88) = 2.15$ ,  $p < .05$ . This interaction was followed up by examining the differences in mean ratings between the types of barrier within each sample. Significant main effects of treatment barriers were found within all location-based samples (metropolitan  $F(5.22, 547.13) = 48.32$ ,  $p < .001$ , Greenhouse-Geisser correction; inner regional  $F(3.95, 106.72) = 6.40$ ,  $p < .001$ , Greenhouse-Geisser correction; OR/ remote  $F(7, 175) = 11.885$ ,  $p < .001$ ). Each of these main effects were followed up with within-subjects main effects comparison, utilising a Bonferroni correction.

Metropolitan-based participants rated Time as a significantly greater barrier than any other ( $ps < .001$ ,  $ds > 10.45$ ), with Participation Restrictions being rated as a significantly weaker barrier than any other ( $ps < .01$ ,  $ds > 3.69$ ). Stigma and Misfit of Services to Needs were also rated as significantly greater barriers than Emotional Concerns ( $ps < .05$ ,  $ds > 3.63$ ).

Time was also the highest rated barrier for doctors in inner regional areas, and was rated as significantly greater than the barriers of Stigma, Emotional Concerns, Misfit of Services to Needs, and Participation Restrictions ( $ps < .05$ ,  $ds > 3.80$ ). None of the other mean differences for doctors within this sub-sample were statistically significant.

For doctors in OR/ remote areas, Time was once again the strongest perceived barrier, being rated significantly greater than all other barriers ( $ps < .05$ ,  $ds > 4.15$ ) except for the Availability of Services and Stigma. Additionally, Availability of Services was rated significantly greater than the barriers of Emotional Concerns, Motivation, or Participation Restrictions ( $ps < .05$ ,  $ds > 3.84$ ).

### **3.2. Qualitative Investigation of Barriers**

Thematic analysis identified two major themes; system-level barriers (three sub-themes) and individual-level barriers (four sub-themes). Within each major theme, results have been prioritised according to extensiveness, that is, the number of participants who raised a sub-theme within each sample. As the emergence of themes did not differ between the regional and rural samples, they were collapsed into one regional sample. Example quotations within each sub-theme (by sample) are contained in Table 3.

**3.2.1. System-level barriers.** *Access to Services* was identified as a barrier across samples, but particularly among the doctors practising in regional locations. Access to services referred to the availability of appropriate professionals within one's geographical area, and in particular, to professionals and services that would be anonymous or removed

from the individual's immediate work or professional networks. It also referred to the knowledge of available services and how to access them within the profession more broadly.

Also cited more frequently by regional doctors and stakeholders than metropolitan doctors (although still reported by all samples), issues of *Professional Culture* were identified as a barrier to service access. Doctors reported a process of tolerance and normalisation of stress and burnout within the profession, whereby high levels of stress were considered either a necessary part of the occupation or were indicative of effort or commitment to the workplace. Cultural issues relating to discomfort in prioritising one's own health or transitioning from a provider to patient role also emerged.

The final system-level barrier identified involved *Professional Consequences* of disclosing difficulties or seeking help. These related to: mandatory reporting and consequences for clinical practice; changes to insurance coverage or premiums; and professional reputation or opportunities for career advancement.

**3.2.2. Individual level barriers.** *Stigma* was consistently reported across samples and related to aspects of perceived structural stigma (that the individual would be disadvantaged or discriminated against in their profession or workplace, e.g., would not be accepted onto a specific training program), perceived stigma from others (that others would think less of them), and self-stigma (e.g., that one should be able to cope without the help of others). Among regional doctors, these views were sometimes also reported in the context of perceptions of regional practitioner identity, such as needing to be stoic or able to withstand stress.

Participants also reported difficulties with accessing services due to a lack of *Time and Prioritisation*. These aspects related to time available to seek and engage with services, whether in the workplace or outside, as well as prioritising patient care and work-related tasks above the individual's own health needs. This low prioritisation of individual

healthcare, although most commonly reported from the individual's perspective, was also at times reported in reference to the individual's organisation or place of employment. That is, that it was perceived that the organisation placed a low priority on the health of its employees.

*Recognition and Awareness* of stress symptoms was also identified as a barrier to treatment, particularly among regional practitioners. This sub-theme included a lack recognition and awareness of symptoms within the individual, as required to prompt them to seek help. However, it also related more broadly to recognition of stress as a problem within the profession, and to the training and education of individuals to be self-aware of their own levels of stress. Interviewees perceived a need for greater training within the profession to assist in recognising and being aware of their own triggers and symptoms of stress.

The final individual-level barrier was *Treatment Attitudes and Expectations*, which was cited by a minority of individuals within each sample. This barrier related to low expectations about the potential benefits of engaging in a treatment program, particularly if that program was a mandatory requirement within the workplace. Participants reported greater perceived credibility of programs if they were offered from within their profession or department as opposed to by external individuals, such as psychologists.

#### **4. Discussion**

The current study examined barriers to healthcare access for stress and burnout among doctors. Such an examination is of particular importance given the high prevalence of stress and burnout among doctors, the adverse consequences associated with the conditions for doctors and their patients, and the low rates of help-seeking that have been reported (Shanafelt et al., 2012; Stanton & Randal, 2011; West et al., 2006). Strategies to reduce barriers and increase treatment access among doctors are imperative to ensuring quality and safety within healthcare systems. It was predicted that regional doctors would report unique

and greater barriers to care. This prediction was partly supported. The quantitative data showed doctors practising in regional areas did not report greater total barriers than metropolitan doctors. However, unique barriers were reported among the samples in both the quantitative and qualitative analysis.

Doctors in OR/ rural areas reported greater barriers to treatment access from a lack of availability of services than did their metropolitan counterparts. This was also reflected in the qualitative analysis, with availability of services being the most commonly reported system barrier among the regional sample. Consistent with a previous systematic review in the area (Kay et al., 2008), system-level factors, such as availability of services and time constraints, were rated highly by participants in the quantitative analysis. Time was the mostly highly endorsed barrier across all samples. As such, in the development of strategies to increase service engagement among doctors, care will need to be given to ensure that interventions and support can be flexibly accessed, particularly for doctors working long or rotating hours, but also that workload is considered in the delivery of these interventions. For example, in larger healthcare organisations allowing protected time, on site access to supports, or incentives for participation may help overcome doctors' barriers in relation to time. Perceptions of access to care pathways have previously been identified as a barrier to treatment for doctors, further supporting the need for tailored interventions and programs for this population.

Of the individual-level barriers, stigma was the mostly commonly reported in the qualitative analysis and reflected the doctors' perceptions of devaluing or discriminating beliefs within the workplace, from others including colleagues, and from themselves. This barrier also varied with regionality, with doctors reporting stigmatising beliefs concerning what it meant to disclose difficulties with stress or burnout as a regional doctor. Furthermore, a heroic conception of stress arising from work as a doctor also emerged across the samples.

Participants indicated that stress was normalised and indicative of commitment to the profession or the workplace. This finding is consistent with previous research which has highlighted the importance of attitudinal barriers among this population (e.g., Cohen et al., 2016; Gold et al., 2016). It will therefore be imperative for intervention strategies in this field to consider the attitudinal barriers to engagement that may need to be addressed for service uptake to increase among doctors. Educational interventions within the profession may assist in reducing stigma. However, it is also likely that attitudinal and culture change may need to be driven and modelled within individual organisations and fields by those in leadership positions. There has been a lack of empirical research in this field focussing on interventions to promote attitudinal change within the profession and should be a priority for future research.

Results of the current study should be considered within the context of a number of limitations. Firstly, the quantitative measure of barriers to treatment used (Mohr et al., 2010) has not been validated for use specific to issues of stress or burnout, or among a sample of medical practitioners. Unfortunately, no such measures with appropriate validation was available; regardless conclusions should be drawn with this in mind and future research focus on the validation of a measure for this purpose. Secondly, it is likely that self-selection into the study may limit the generalisability of results. That is, the doctors who participated in this study responded to recruitment strategies advertising a study focused on doctors' health and wellbeing. As such, it is unclear how representative the current sample is of the broader population. Despite these limitations, a number of strengths should also be noted.

Previous research in this field has identified a lack of rigorous and systematic examination of barriers to service access among medical doctors, with claims to date being primarily based on opinion rather than evidence (Kay et al., 2008). This study has addressed this limitation, as well as giving greater attention to the heterogeneity of doctors as a group,

which has also been identified as an area of need (Elliot et al., 2010). In particular, this study focused on potential differences in access to services across regions, providing insight into the strategies that will be needed to improve access across these different populations.

This research highlights that a number of barriers need to be addressed in order to improve service access for stress and burnout among doctors. Greater availability of services needs to be a priority in improving access among regional based doctors. Furthermore, employers and policy makers will need to address the barriers doctors experience regarding time and the prioritisation of their own healthcare needs. In doing so, using creative methods to encourage engagement will likely prove necessary, such as by the development of programs in which doctors may be able to claim professional development, or alternatively by offering individuals protected time in the workplace to engage with services. Furthermore, educational strategies within the profession to encourage awareness and reduce stigma may also be beneficial in overcoming cultural barriers. Tailored targeting of the identified barriers will be essential in improving uptake of psychological services by doctors in need, promoting improved outcomes for doctors, their workplaces, and communities.

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