

# Exploring the subjective burden of confidentiality among physicians in Norway

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## ABSTRACT

**Background:** Concern about protecting patient privacy is proposed to be a barrier for physicians to talk about emotional distress from their professional experiences. This makes it difficult for many physicians to utilize and fully benefit from different network of social support. The subjective burden of confidentiality is reported to be associated with physician's health and wellbeing. **Aims:** To gain knowledge about factors in the in personal and professional sphere that can be associated with the subjective burden of confidentiality. **Methods:** Qualitative semi-structured interviews with 14 general practitioners and hospital physicians in Norway. Examination of transcribed verbatim interviews using qualitative content analysis. **Results:** The subjective burden of confidentiality is likely linked with factors such as perception of professional role, social support from colleagues, partners and friends; size of patient population, organizational factors and work environment, and the overlap between personal and professional relationships. **Conclusions:** Addressing the interaction of emotional demands and patient confidentiality is important to study successful coping with distress from physician's professional experiences.

**Keywords:** Professional secrecy; doctors; ethics; work stress; social support; work environment

## 1. INTRODUCTION

Although physicians are educated and trained to be capable and mentally prepared to handle patient's misfortune, it is inevitable that they can be emotionally affected by their patients. Situations that can cause emotional distress can range from one major traumatic event

to several critical incidents over a short period of time [1,2], including everyday routine situations [3-5]. As exposure to emotional job stressors usually cannot be reduced, the physician's ability to cope with emotional demands is important in order to prevent stress [6,7]. The most common method physicians apply to cope with emotional distress involve turning to others for support [8]. Previous research has confirmed that support from others is a critical resource to foster adjustment to distressing events, and of considerable significance for people's health and wellbeing [9].

A key assumption in research on stress and coping is that people centralize their own needs. However, in many situations people must prioritize other people's needs or other important personal and professional values and goals. Competing priorities in coping, such as concerns about own confidentiality [10,11] or the need to maintain or protect ones own or their in-group professional integrity [12,13], can act as a barrier to seek support from others. In addition, the concern about protecting other people's privacy in terms of discretion and client confidentiality is also an important barrier for support seeking in emergency- and human service professionals [14]. A recent cross-cultural study showed that about 30% of hospital physicians regarded patient confidentiality as a considerable barrier to seeking emotional support from their professional and personal network [15]. In this study, the interaction between emotional demands, patient confidentiality and coping was clearly associated with physician's health and wellbeing [15].

As concerns about patient's privacy seem to be relevant for physicians coping with emotional distress from their professional experiences, it is interesting to gain knowledge how confidentiality mediates coping with emotional distress, and factors in their personal and professional sphere, which can be associated with the subjective burden of confidentiality. This includes an explicit focus upon physician's coping with emotional distress from their professional experiences, and how they resolve

these possible challenges in light of the norms and rules of patient confidentiality. We are here primarily interested to reveal examples and patterns in how patient confidentiality is practiced, which explain the current research design based upon in depth interviews of Norwegian physicians, rather than a quantitative approach. The qualitative study supplements and supports more quantitative driven research on the role of patient confidentiality for professionals in emergency and human services [14,15].

## 2. METHODS

In-depth interviews were carried out in a sample of 14 practicing physicians working in two Norwegian health regions. Nine were general practitioners (GP), four were oncologist from a hospital with patients from the whole country, and one senior consultant was specialized in treatment of physicians with health problems. Participants were recruited based on recommendations from their colleagues and superiors. Our concern was to explore contrasting experiences among the ones interviewed. In order to do so it was important to have a mixed sample in terms of experience and type of medical practice (**Table 1**).

The interviews were conducted as semi structured individual interviews with open-ended questions, and held in the physician's office. The interviews lasted from 45

minutes to 3 hours, on average taking 1 – 1.5 hours. Participants were asked open-ended questions. Core concepts were pursued flexibly in the individual interviews, according to the topics that appeared most adequate during the conversation. The participants were asked to give a short summary of their current position, education and career as physician. The interview covered topics of emotional distress from their professional experiences, coping with distress and the ways in which confidentiality affected them in various situations at work and outside work.

Physicians were encouraged to speak freely and raise issues concerning confidentiality that were important to them, and to support their responses with examples. We avoided a focus on judgments of individual decisions as right or wrong practice of confidentiality [16].

The interviews were taped and transcribed, and then the interviewer and co-workers verified the transcriptions. In the analysis and coding of data, this study followed Miles and Huberman's [17] qualitative research method. Two researchers separately coded the data, and the codes were later compared in order to reconcile discrepancies and reach consensus to ensure the validity of the interpretations made. Qualitative content analysis of text was conducted on several levels. Initially, we looked in detail at the transcript of each interview, starting with particular

**Table 1.** Characteristics of interviewees.

No.	Gender	Age	Hospital	Position*	Location	Patient population (N**)	Head of dept/ med. office	Partner's occupation
1	M	50	No	CMMO	District	1' - 10'	Yes	Psychologist
2	M	44	No	CMMO	District	1' - 10'	Yes	Unknown
3	M	54	No	GP	City	10' - 200'	No	Teacher
4	F	29	No	GP	City	1' - 10'	No	Unknown
5	F	49	No	GP	City	1' - 10'	No	Physician
6	M	48	No	CMMO	District	1' - 10'	Yes	Physician
7	M	40	No	GP	District	10' - 200'	No	Housewife
8	M	44	Yes	SSC	District	10' - 200'	Yes	Nurse
9	M	52	No	GP	City	1' - 10'	No	Nurse
10	M	50	Yes	SSC	City	>4 500'	Yes	Not physician
11	M	48	Yes	SC	City	>4 500'	No	Physician
12	M	54	Yes	SC	City	>4 500'	Yes	Physiotherapist
13	F	45	Yes	SC	City	>4 500'	No	Physician
14	M	40	No	CMMO	District	< 1000	Yes	Single

\*GP = General practitioner/(S)SC = (Section) senior consultant/CMMO = Chief Municipal medical officer. \*\*numbers in thousand.

examples, and worked our way up to more general categorizations. Each interview was read several times, searching for respondent meanings [18]. During this process, all the interviews were carefully read and key words and notes were gleaned from each document, in order to illuminate the research questions. Then we looked for clusters of themes. A set of codes was related to a single interview and then compared to all interviews for differences and similarities. At the end, the text was condensed into themes and coherently organized.

### 3. RESULTS

The responses from the Norwegian physicians' illuminates that concerns about protecting patient's privacy can be a source of stress for physicians (Box 1).

The subjective burden of confidentiality was primarily associated with factors such as; 1) perception of professional role, 2) social support, 3) partner's occupation, 4) size of patient population 5) work environment and 6) the overlap between personal and professional relationships. We were not able to identify any diversity of situations or themes based on gender.

#### 3.1. Perception of Professional Role

The subjective burden of confidentiality increased as a result of incongruity between personal needs and the desire to display a certain professional image. In line with this confidentiality fortifies the image patients have of the "perfect physician": responsible and devoted. Upholding a professional image of competence, confidentiality, and emotional capability comes with a price tag, and at the expense of the personal need to deal with emotional demanding parts of their work (Box 2.1).

#### 3.2. Social Support

A general coping strategy, confirmed by most of our physicians, was to confide in other people by without revealing patient names or other personal features. They were particular about who they shared emotional work experiences with and where they did this. The physicians saw the necessity to vent feeling with people they felt particularly close to, often rooted in a longstanding relationship with mutual respect and trust, such as an ex-

perienced colleague, partner, family member or a close friend. As such, the provision of social support for them was not only a matter of confidentiality, but also the quality of interpersonal relationships. Many participants reported that confidentiality became a barrier for using non-physicians as a source of support. This was a source of distress, because it limited the physician's network of possible confidants, and could have a negative effect on their personal relationships (Box 2.2).

#### 3.3. Partner's Occupation

In addition to trusted colleagues, partner was one of the most important source of comfort and ease of distress from work. Physicians whose partner was a physician saw this as an extra advantage as both the clinical and emotional part of their work could be discussed more openly in an ethically safe framework of confidentiality (Box 2.3). However, physicians who had partners in other occupations did not express that they felt it "irresponsible" to confide in their partner or that partner's occupation was a disadvantage. Those who preferred to share emotional distress from their work experiences with their partner vindicated this through their "internal confidentiality" regardless of partner's occupation, where confession is based on mutual trust that the information is in a safe place (Box 2.3).

#### 3.4. Size of Patient Population

The roles of colleagues varied according to what kind of work context and patient relations the physicians were involved in. An encouraging and interdisciplinary work environment was often a positive supplement to the lack of physician colleagues for physicians working as a solo practitioner or in a thinly populated district. Small units, although having only one physician, have other health care employees who are involved with the same patient. In this respect the physician could discuss issues of concern with someone at work, especially with nurses. This was justified by the internal confidentiality present at the health care centre, ward or organization. A common pattern was that turning to non-physician colleagues at work was more common for physicians mainly working alone, the co-worker had considerable seniority and a high level of empathy, or when the work environment between physicians was competitive and unsupportive.

#### 3.5. Work Environment

Confidentiality and graded information could make in-group relations stronger among physicians and contribute to a division of professional groups, specialties or units of physicians within the hospital or medical office. In light of this, the confidentiality code may both work as

#### Box 1. The subjective burden of confidentiality

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If I think about it as a professional, then confidentiality works just fine. It is as it should be and confidentiality functions well. That's the official version. Yet at the same time, I know as a person, that if it didn't exist I could have managed some situations better. I believe so

Patient confidentiality like a straightjacket and stops you from airing the difficult things that trouble you.

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a factor to maintain professional integrity, as well as a stressor and barrier for seeking social support with non-physicians. This was particularly evident among the physicians working in hospitals. Even though the climate between physician co-workers was not good (Box 2.4), many felt they could not go beyond professional “borders” and talk to non-physician co-workers.

The realization that graded information might create a hierarchy and different in-group relations at the work place was compensated by creating alternative and less hierarchical modes of collaboration between physicians and non-physicians (Box 2.4). The extended network of possible confidants appears to have made it easier to share demanding work experiences with co-workers they valued and relied on regardless of the co-workers profession. An important issue related to coping with emotional distress and confidentiality was the absence or presence of forums debriefing at the workplace. Such forums were according to those interviewed important for managing stressful situations in an ethically safe manner. These forums, informal and formal, were typically a result of the combination of work environment, organizational structure and personal initiative from seniors at the ward or health care centre. Although a formal forum existed in the quality system of the organization, most often physicians or co-workers used informal forums, such as Monday morning coffee breaks, staff meetings and lunch or private conversations between two physicians. These forums were not regarded as loose talk about patients, but described as an advice seeking situation held with respect for patients and confidentiality (Box 2.4).

### 3.6. The Overlap between Personal and Professional Relationships

Privacy may be compromised when professional relationships are interwoven with personal ones (Box 2.5). Physicians that worked and live within a small community faced situations where they had to be aware of confidentiality in interpersonal relationships. The GP's in the small rural practice said that having friends and colleagues as patients was almost a weekly occurrence. Though, also physicians working in larger communities and hospitals faced these situations when treating colleagues or members of a social group they belonged to. Younger physicians had not yet worked up a pool of patients that made confidentiality as challenging in interpersonal relationships in this regard. As a “newcomer” they did not know many people in their community. This was perceived as an advantage in order to avoid emotional connection with patients or distress by identification with patient's life status. The need to keep professional and personal relationships separate was also the reason why many physicians preferred to live in their

neighbor municipal or district than the one they worked in.

The amount of personal information the physician found comfortable and appropriate to know about people they knew set the premise for these kinds of consultations and encounters. Some physicians preferred to completely separating the roles by refusing to treat people they knew well. Others did not have this strict division between the private and professional. However, the extent in which they treated people was limited. Some chose to only write out prescriptions, treat minor illness, perform superficial examinations and refer people to proper treatment/skilled clinicians. Some physicians drew the line between physical and psychological/psychiatric issues, and did not assist people with issues that had great emotional impact such as sexual issues, family crisis, suicide attempts and such. Still others had no separation between someone they knew and any other patient; they treated them equally regardless of the patient's problem. When communication in social situations became a clinical encounter or addressed medical concerns, the physicians often used confidentiality as a tool to actively force the encounter into a professional relationship or setting. In these situations, confidentiality became a buffer of potential relationship stress; it regulated how the professional role came forward in a private setting in a manner that protected the integrity of both parties and their relationship in the future. They always ensured that the consultation was conducted in their medical office. Or they explicitly specified that they are in the role of physician during the consultation (Box 2.5).

This study may extend our understanding on the relationship between protection of patient's privacy and physicians coping with work related emotional distress. The results from the interviews with physicians suggest that organizational, professional and personal factors, which reinforce one another, may contribute to the subjective burden of confidentiality. For example, a hospital ward with a hierarchic structure and unsupportive climate might have a different impact on this matter than a supportive work environment with a network of consistent boundaries regarding the psychosocial work climate. This is in line with previous research where physicians are shown to have different attitudes to and practice of confidentiality [19,20], their professional role [21,22] and coping strategies used to deal with ethical [23,24] and emotional [25] discomfort in their work. Based on the current results, these factors are likely to be associated with how physician manages emotionally-charged work situations and confidentiality.



**Box 2.** Factors associated with the subjective burden of patient confidentiality.

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2.1 Professional role	<p>Confidentiality causes one to become an individualist. One must give the impression of being present and complete secrecy of all information- and because of this, it is important to maintain an impression that information is not easily exchange between us doctors [No.1]</p> <p>Confidentiality is the problem; it is so strong and important that it hinders debriefing because of fear of showing weakness in a profession that is supposed to be “elite” [No. 6]</p> <p>One also has professional pride in that information should be kept to oneself [No. 8]</p>
2.2 Social support	<p>Because of confidentiality, I primarily rely on my colleagues, perhaps more so than my partner [No. 5].</p> <p>I don’t usually discuss concrete situations from work at home. One main reason for this is confidentiality. My partner has said that it puts distance between us. But there is something about confidentiality...it happens quite fast that you’ve suddenly said a little something. It’s much easier to say nothing at all about your professional experiences [No. 10].</p> <p>Most often you have a few people you feel particularly close to. And I have mine. It does not have to be a physician. It is more personal, and is a matter of trust and personal chemistry [No. 10]</p>
2.3 Partners occupation	<p>My wife is a nurse, and I do not believe that I violate confidentiality when I talk to her [No 9].</p> <p>Confidentiality limits the kind of issues you bring at home. However, my partner works in the health care system. This makes it easier [No. 9]</p> <p>Though I can speak with my colleagues, I believe it is common to speak with your partner. At least if your partner is a physician. We have an internal confidentiality, were I can share confidential information about patients, and know that it is in a safe place. It is probably not legal at all [No.11]</p>
2.4 Work environment	<p>It is a bit problematic to use other co-workers as confidants. We have some of the traditional separation between physicians and nurses. I feel that to a certain extent I have to maintain loyalty to the physicians and not take the nurses into confidence in regard to how much information I give. That’s the way it is, it’s like an unwritten rule here [No. 10]</p> <p>Of course the medical meetings between doctors are important. However, because the house staff is a large part of the medical centre, it should not be a difference between us. They perform many clinical functions and have much knowledge about the patients. Often it is the same patients that are challenging for us doctors, as it is for them [No.5]</p> <p>It is more important to emphasize the ward and that those who work here is a unit. Particularly because we are exposed to the type of cases we have here. I mean, it becomes wrong if I constantly emphasize [a hierarchy] that I am a senior consultant, and you a resident, next a poor intern, after that a nurse and then an enrolled nurse. Of course I have the main responsibility, but it is not necessary to demonstrate a visible power in the ward through confidentiality and rank. Everyone know their tasks, and all serve the same purpose; working together with in the best interest for the patient. And the enjoyment and challenges we experience are something that we are going to share [No. 12]</p> <p>I think it’s important to have a place where you can be together and laugh about the frustration you have about patients. I don’t feel that confidentiality is a barrier to that. When I go to a colleague and talk about little things that happen, it’s between us. That is a freedom we take [No.6]</p>
2.5 Personal and professional relationships	<p>Confidentiality complicates my life. In social situations it complicates my life. In professional situations I think it is easier to handle [No.3]</p> <p>As we have a more personal relationship with patients as general practitioners we place a major importance to ensure confidentiality [No. 1]</p> <p>In contrast to hospital physicians who focus more on “cases” that lays along the hospital beds. I think this personal relationship facilitates increased awareness on confidentiality among general practitioners than hospital physicians [No.1]</p> <p>Confidentiality regarding family and friends is difficult - incredibly difficult. Close friends who have problems. There I sit at a party with them and maybe before I sat and spoke with them about their worst life trauma [No. 3]</p> <p>When they [friends] come to my office, they see me more as a physician. If they visit my home and we are chatting at the kitchen table, then in this situation I am talking with them as a friend. I think this makes them feel safe as well. There is something to learning how to separate the private and the professional realms, you know. You will come into some problems regarding confidentiality if everything gets mixed together [No.5]</p> <p>There isn’t as much leeway for how to build a friendship. Because I have information that I don’t want to have between us, but it is there anyway [No.1]</p>

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**4. DISCUSSION**

The present results indicate that a positive work environment alleviated the subjective burden of confidentiality. In addition, multidisciplinary teams with good, open communication provide a forum for shared experience as well as shared knowledge and informa-

tion. Interestingly, participation in meetings to discuss stressful work situations seemed to be helping to vent feelings both in a personal, and ethical, suitable manner. To build a common experience base may eliminate the need for detailed information in daily communication with fellow workers as the emotional reaction becomes readily recognizable without it [26]. This might

counteract the subjective burden of confidentiality.

Confidentiality was also perceived as a tool that protects the physicians from possible relationship distress. Interweave between personal and professional spheres for physicians have received increased attention the last decade [27,28]. Rourke and his associates have focused on boundary issues that may evolve due to treating own family members and friends [29]. All physicians, regardless of specialization, face such situations from time to time; though being a physician in a small community pose more frequent and proximal interpersonal challenges in this regard. Miedema, Easley, Fortin, Hamilton and Tatemichi's [30] study on how the trespassing of patients onto the physicians' personal live in small towns and rural communities, illustrate this issue. Our study shows that the physicians used confidentiality as a tool to force such personal encounters into a professional setting in order to protect both parties integrity.

The participants in this study represent a selected sample which might have been more reflective than the average physician and more willing to expose personal demanding situations and/ or situations where confidentiality as a norm of behavior has been compromised. The point of situations and themes that came up in the interviews with the GPs, corresponded with the hospital physicians'. We have no reason to believe that the basis for the experiences of those who participated in this study to differ from those of their colleagues. Tough their willingness to make these experiences explicit may be a deviation from the general population of physicians. Most of the interviewed had a long work experience and in depth thoughts about the topics addressed. The disadvantage of this kind of sample is of course that we might have missed out interesting dilemmas among junior physicians. This said, when the physicians were asked to recall particular matters as inexperienced physicians, none did mention any previous experiences were the role as a subordinate was a problem in this regard. They rather focused on the importance of finding a trusted friend, preferably a fellow colleague to share stressful work experiences with, regardless of position or experience. The sample is over-representative for men. This reflects the proportion of GPs and oncologists in Norway where the majority is male (Statistics, The Norwegian Medical association, 2009). Interestingly we have not been able to track any systematic gender differences in the topic addressed by the participants. Some of the male physician believed that female colleagues would find confidentiality more challenging under the assumption that women in general prefer to share their emotions and seeks support more than men. We have not found any support for this in the current study or in correspondent research [14,15].

When the respondents in our study report that inter-

professional relationships and confidentiality are crucial factors for inhibition and seeking emotional support, it is important that the organization facilitate a communication atmosphere that address both the technical and emotional parts of medicine. In addition, that experienced physicians take the lead in promoting professional change on this matter. An advisory service from skilled seniors might create a competence beyond the medical and technical aspects of the medical profession.

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