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SELF-REGULATION

An act of performance: Exploring residents' decision-making processes to seek help

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Abstract

Context: Residents are expected to ask for help when feeling insufficiently confident or competent to act in patients' best interests. While previous studies focused on the perspective of supervisor-resident relationships in residents' help-seeking decisions, attention for how the workplace environment and, more specifically, other health care team members influence these decisions is limited. Using a sociocultural lens, this study aimed to explore how residents' decision-making processes to seek help are shaped by their workplace environment.

Methods: Through a constructivist grounded theory methodology, we purposively and theoretically sampled 18 residents: 9 juniors (postgraduate year 1/2) and 9 seniors (postgraduate year 5/6) at Amsterdam University Medical Centers. Using semi-structured interviews, participating residents' decision-making processes to seek help during patient care delivery were explored. Data collection and analysis were iterative; themes were identified using constant comparative analysis.

Results: Residents described their help-seeking decision-making processes as an 'act of performance': they considered how asking for help could potentially impact their assessments. They described this act of performance as the product of an internal 'balancing act' with at its core the non-negotiable priority for providing safe and high-quality patient care. With this in mind, residents weighed up demonstrating the ability to work independently, maintaining credibility and becoming an accepted member of the health care team when deciding to seek help. This 'balancing act' was influenced by sociocultural characteristics of the learning environment, residents' relationships with supervisors and the perceived approachability of other health care team members.

Conclusions: This study suggests that sociocultural forces influence residents to experience help-seeking as an act of performance. Especially, a safe learning environment resulting from constructive relationships with supervisors and the approachability of other health care team members lowered the barriers to seek help. Supervisors could address these barriers by having regular conversations with residents about when to seek help.

1 | INTRODUCTION

Complex, critical and challenging situations during the delivery of patient care are an everyday reality for residents. In such situations, residents are expected to seek help when they feel insufficiently able, confident or competent to act in patients' best interest.[1-5] However, several studies suggest that residents may be hesitant to seek help, which could jeopardise the quality of patient care[1,2,5,6] and result in a loss of learning opportunities.[3,6] Research highlights the complexities involved in residents' decisions to seek help, especially in relation to their supervisors, due to the existing hierarchy.[1-8] Approachability and availability of supervisors determine the experienced threshold for residents to seek help[2,5,8] but do not eliminate worries residents have about how they might come across when asking for help from their supervisors.[5,6] Even when supervisors are approachable and available, residents still fear losing their autonomy[8] and professional credibility[2] or being seen as incompetent.[1,4] As a consequence, residents might refrain from asking for help or employ strategies to maintain their image of being a 'credible' or 'believable' physician.[6]

Although, thus far, studies foregrounded the perspective of supervisor-resident relationships in residents' asking for help, only considering this perspective may not be sufficient to understand residents' help-seeking decisions. As patient care requires the joint effort of health care teams, residents interact with many different health care professionals on a day-to-day basis. From the perspective of sociocultural learning theories, our eye is drawn to how learning arises from these interactions that residents engage in and how interactions are influenced by the cultural practices within the workplace environment.[9-12] Bleakley[13] argues that the sociocultural perspective is especially helpful in understanding how learning and social practices occur in complex systems such as health care teams. Similarly, organisational psychologist Bamberger[14] advocates for considering not only help-seeking as an individual trait but also to examine the interplay between the help-seeker and provider within the workplace.

While studies within medical education have more and more adopted the sociocultural lens to advance our understanding of workplace learning,[15-19] it has not yet been used to study residents' decision-making processes to seek help. Hence, attention for the extent to which residents decide to seek help from other team members is still warranted. Some empirical examples do already touch upon the role of the other health care team members and the workplace environment.[2,20,21] For instance, Kennedy and colleagues,[2] described how residents turned their questions to 'less powerful' team members (eg nurses and peers), to maintain their credibility towards supervisors or when supervisors were not available. Olmos-Vega and colleagues[8] highlighted that if residents perceived an unsafe workplace environment, they requested help from peers as it felt safer to ask from an equal team member.

Using a sociocultural lens, this study sets out to understand residents' decision-making processes to seek help regarding patient care. Such an understanding could provide useful starting points for safeguarding patient care and enhance learning opportunities during residency training. The current study aims to explore how residents' decision-making processes to seek help are shaped by their workplace environment, including their experiences of the social and cultural practices in the workplace.

2 | METHOD

We used a constructivist grounded theory (CGT) methodology as we sought to explain how residents' decisions to seek help are shaped as a social process embedded in the workplace.[22] Following this methodology, our data collection and analysis were iterative, meaning that each informed and influenced the other.[22,23] To inform our data collection and analysis, we used sensitising concepts from sociocultural learning theories, in line with the constructivist approach.[22] These theories are based upon the idea that residents' learning results from the interplay between individual agency and the social and cultural context.[9-12] We specifically used ideas from theories on workplace learning,[10,24] Communities of Practice[11,12] and Landscape of Practice.[25,26] Using these ideas allowed us to study residents' perceptions about their decision-making processes to seek help, while also being aware how these processes are shaped by their social context with the specific focus on interactions between health care members and the underlying workplace culture. This research was conducted by a sociologist pursuing a PhD in medical education (IJ), an educationalist with expertise in qualitative methodology (RS) and, two health care scientists (MS and KL). RS, MS and KL are experienced researchers with respectively significant expertise in workplace learning, learning environments and the medical profession.

2.1 | Setting

This study was conducted among residents at Amsterdam University Medical Centers (Amsterdam UMC) in the Netherlands. In the Netherlands, the duration of residency training varies per specialty and lasts between three to six years. As in other Western health care systems, obtaining a position within residency training is very competitive.[27] During their training, residents follow various rotations in both academic and (several) non-academic teaching hospitals, where they are part of the health care team and work alongside multiple health care professionals (eg nurses, fellow residents and supervisors). As residents progress through their training, they will gradually and, with guidance from their supervisors, work towards independent practice. Lastly, competency-based medical education (CBME) and systematic quality assessments and improvements have been implemented in Dutch residency training programmes over the past decade. Measuring residents' learning climate, the use of Entrustable Professional Activities (EPA's) and residents providing feedback on their supervisors' teaching qualities, can be considered a routine practice in most Dutch training programmes.[28,29]

2.2 | Sampling and data collection

We purposively sampled residents from internal medicine, paediatrics, and obstetrics and gynaecology training to encompass different work settings, regarding the nature and urgency of care, the type of health care team members, how team members collaborate, as well as the culture within the workplace providing rich information aiding to understand residents' decision-making processes. We purposively included junior residents (postgraduate training year 1/2) and senior residents (postgraduate training year 5/6). It is suggested that residents' decisions to seek help might be expressed differently depending on their level of training.[2] In a later stage, we used theoretical sampling,[22] seeking residents from surgery training programmes and higher postgraduate years to deepen the findings and capture the comprehensiveness of the preliminary defined results (see Table 1). Invitation e-mails, including a brief study description and an information letter, were sent to residents. Participation in the study was voluntary at all times.

The initial semi-structured interview guide was developed by the research team and piloted with one resident. The guide was refined by reformulating questions that were not well understood by the participant (see Appendix S1). During the interviews, residents were asked to describe the process by which they seek help, using probes based on residents' responses and previous findings to further explore residents' decisions to seek help.[23] Following CGT methodology, after examining the transcripts, recurring themes were deepened during subsequent interviews using a refined interview guide.[22] Notably, as residents were hesitant to use the word 'help-seeking' or said never to ask for help, we used similar but less pejorative terms for help-seeking, that is 'checking' or 'consulting' at the start of the interview. After establishing rapport between the interviewer (IJ) and participants, we explicitly referred to 'help-seeking' and the phenomenon's sensitivity.

Theoretical sufficiency was met after interviewing eighteen residents, meaning that we had collected sufficient data to understand and explain residents' help-seeking decisions for this study.[30] All interviews were conducted between January 2019 and December 2019 by the first author IJ and lasted between 40 and 65 minutes. Interviews were audiotaped, transcribed verbatim and anonymised before data analysis.

TABLE 1 Characteristics of residents interviewed (N = 18)

Characteristic	No.
Gender	
Male	5
Female	13
Level of training	
Junior	9
Senior	9
Training programme	
Internal medicine	9
Paediatrics	2
Obstetrics and gynaecology	5
Surgery	2

2.3 | Data analysis

The first four transcripts were read and open coded independently by IJ and a research assistant with expertise in qualitative methods. During this process, RS and MS additionally double coded parts of the transcripts to compare the interpretation of initially developed codes. After approximately ten transcripts, we iteratively refined initial codes during regular team meetings until we agreed upon a preliminary code scheme with major categories, capturing relationships between codes (axial coding process). The preliminary code scheme was an iterative and ongoing process applied to the next five transcripts and further refined through group review and discussion. After the team agreed on the refinement, the scheme was applied to the subsequent transcripts. We then constructed the relationships among categories, facilitating a deeper conceptual understanding of residents' decision-making processes to seek help. To check whether the constructed conceptual framework captured residents' decision-making processes to seek help, we discussed the framework during two final interviews with residents,[30,31] who had the same characteristics as described in the sampling section. Our discussions with these residents suggested that the framework resonated with their experiences and, they provided further details supporting the framework we had constructed. As such, no major changes were made to the framework. MAXQDA (version MAXQDA Plus 2020) supported data analysis.

3 | RESULTS

Residents described their decision-making processes to seek help as an *act of performance* in which they considered how their asking for help could be taken into account in their assessment as a learner and future medical specialist by all members of the health care team. This act of performance was described as the product of an internal 'balancing act' and how residents' perceived certain sociocultural forces within the workplace. During this balancing act of whether or not to seek help, residents considered four aspects: 1) providing safe and high-quality patient care, 2) demonstrating the ability to work independently, 3) maintaining credibility as a (junior) physician and 4) becoming an accepted member of the health care team. Three sociocultural forces of the workplace strongly influenced the weighing of these aspects: a safe learning environment that was conveyed through a constructive relationship with supervisors and the approachability of other health care team members (Figure 1).

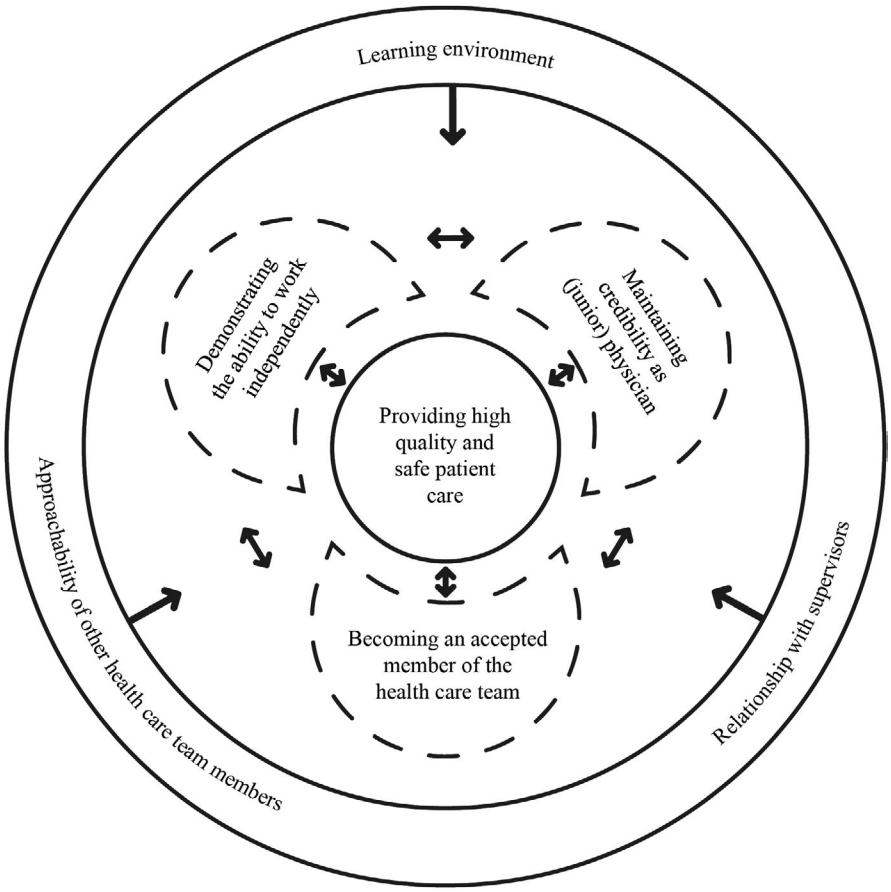

FIGURE 1 Conceptual model of how residents' help-seeking decisions are shaped. Residents' internal dialogue and the four aspects they balance are portrayed in the middle. The outer ring displays the forces within the workplace influencing which aspects were given more weight in residents' decisions to seek help or not

3.1 | Residents' internal dialogue: the balancing act and act of performance

Residents likened asking for help as an act of performance: they felt that asking for help could positively or negatively impact their assessments. As such, asking for help was experienced as high-stakes or low-stakes, depending on the patient case and who they wanted to ask help from within the health care team. Residents described that the decision to ask for help was each time preceded by an internal dialogue in which four aspects were considered. Although individual differences were apparent, the same four aspects were consistently present within residents' help-seeking considerations regardless of residents' gender or training programme. Residents' desire to *provide safe and high-quality patient care* was the core around which their internal dialogue revolved. When residents considered asking for help from supervisors, *maintaining their credibility*, and their drive to *demonstrate the ability to work independently* were most pertinent. *Becoming an accepted member of the health care team* was mostly considered when seeking help from members of the health care team in general and physicians from other departments.

The balance between providing *safe and high-quality patient care* and *maintaining credibility* could raise tensions and cause conflicting feelings for residents towards seeking help. Residents, for example, explained this tension as preferring more information or details about a clinical case. However, asking for such details could be at odds with maintaining their credibility in the eyes of their supervisors. By asking questions that might be perceived as 'dumb' (P2) or 'inappropriate' (P7) by supervisors, residents worried about performing in a wrong way, harming their credibility, which could negatively impact their assessment:

> And then I notice that asking help from people who also have to assess you immediately creates a risk (…) Because if they [supervisors] interpret a question as, oh, she doesn't know (…) I think that it just affects the assessment you get as a resident.
>
> (P12)

Furthermore, residents described that seeking help in non-urgent or less complex clinical situations (eg small laboratory abnormalities) was challenging: seeking help in such situations was recognised as generally preferred for *safe and high-quality patient care*, while at the same time residents wanted to *demonstrate the ability to work independently*, strengthened by the feeling that this was expected from them as a physician in training. This challenge seemed to affect junior and senior residents differently. Juniors felt not yet fully able to work independently and talked about the desire for a final 'confirmation' (P10) or 'reassurance' (P6) from supervisors, indicating that they were making the right clinical decisions for their patients. Seniors, on the other hand, reflected

that the ability to work independently without seeking help became more important and that both asking too many questions and being 'indecisive' (P18) was not a desirable performance as 'it [reputation of indecisiveness] will stick to you' (P18). Interestingly, to perform well, one resident talked about being a 'chameleon' (P15): adapting the way of working and asking questions to what is perceived as expected to do. As a consequence, this resident said 'sometimes you're acting a little bit'. (P15).

While residents perceived that seeking help to provide safe and high-quality patient care could run counter to maintaining their credibility and demonstrating the ability to work independently, residents experienced that *becoming an accepted member of the health care team* went hand in hand with *providing safe and high-quality patient care*. Residents described how, by deliberately asking questions, they learned how 'things are done' (P4) within this particular workplace and simultaneously could establish collegial and reciprocal relationships needed to become an accepted member within the health care team. In turn, being accepted and included as a full team member afforded residents in current and future clinical cases to get the daily patient care done: 'that people enjoy working with you and are willing to work half an hour overtime so that we can finish surgery (…)'(P15).

3.2 | Forces within the workplace influencing the balancing act

Residents' described how forces within the workplace inherently influenced their help-seeking balancing act. Within the workplace, a safe learning environment was repeatedly described as a force influencing the balancing act. It created a sense of safety that was conveyed through a constructive relationship with supervisors and the approachability of other health care team members. These forces, including whom they were seeking help from, influenced which aspects were given more weight in residents' decisions to ask for help.

3.2.1 | Safe learning environment

Residents recognised how the experienced learning environment within the workplace shaped their decisions to seek help, especially their sense of a safe and constructive atmosphere was imperative. Residents described such an atmosphere as 'open' (P9), 'welcoming' (P4) and 'equal' (P3) in which they were being recognised as a person as well as a learner by team members. In such departments, residents felt more included within the team and were more comfortable to share clinical uncertainties:

> And if you ask or say something, it is listened to and addressed. So, the feeling that you are a team (…) Not that all decisions are made for you from above, but that you are also heard. (…) then you just feel like a full member of the team. And that has the effect (…) on me that you feel happy, you feel comfortable, and you feel safe. I think it promotes safe patient care because you feel free to ask and to share your doubts.
>
> (P3)

In contrast, in more punitive atmospheres, residents experienced the feeling of being 'punished' (P17) for asking questions or being 'constantly assessed' (P11). In such atmospheres, residents felt this burden always lurking, which affected their asking for help in current and future help-seeking situations throughout their training: 'that you choose to make a plan [for the patient] yourself instead of discussing your doubts [with supervisors]' (P3).

3.2.2 | A constructive relationship with supervisors

Residents considered supervisors who shared their expectations about when and how they should seek help as contributing to a constructive relationship. Such conversations positively influenced residents' help-seeking decisions, mitigating the odds of losing credibility and the need to perform questions. However, these conversations were very rare, causing residents to turn to fellow residents and nurses who helped them to understand their 'supervisors' manual' (P15) (eg supervisors' expectations and preferences regarding help-seeking). Especially junior residents pre-consulted nurses or fellow residents about 'whether they also find it [ECG] normal or abnormal, or whether you should consult a supervisor' (P11). As this other resident explained:

> I often ask the nurses, what do you think? Just for back-channeling, that you are more certain about what you want to discuss [with supervisors], or whether your treatment policy is the right one.
>
> (P15)

Residents also described how a nonconstructive relationship with and strong reactions from supervisors to requests for help had them 'trying to find a work-around not having to ask the supervisor in question' (P3), because—as one resident put it—'you do not want to be the pain-in-the-ass resident' (P17). Residents then preferred 'thinking about that [question] later [by myself]' (P10). A typical example was supervisors who acted too hurried or rushed to answer questions:

> My supervisor came into [the room] in a hurry holding a sandwich: 'I have 25 minutes, 8 patients, just quickly'. And then you look through the [lab] results together. [supervisor says] 'Do you have any questions? No okay, and continue'. It is just: you report and they dictate. (…) While you do not even know yet why a CT, why not an MRI?
>
> (P10)

3.2.3 | Approachability of other health care team members

Residents spoke about fellow residents and allied health professionals' approachability as they often worked physically close together by sharing offices. Such proximity lowered the threshold to ask quick and 'practical things [to fellow residents] about (…) how do you make a discharge letter or how do I go through medication changes?' (P10). Whereas calling supervisors from other departments was 'difficult because you sometimes don't know who you are calling' (P1). Working physically close to each other thus facilitated a relationship based on trust, support and, reciprocity by which help-seeking 'went more smoothly' (P2). Residents recognised that their own attitude towards nurses contributed to such a reciprocal relationship:

> I also invest very actively in it [relationship with nurses] and approach them with a lot of respect and I explicitly thank them if they do things that—as a result—I do not have to do. (…) I think if you are kind to each other that way, it helps in on all sides. It also helps me in the end, because next time they are willing to call a patient again.
>
> (P17)

Moreover, residents indicated how they experienced a lower threshold when seeking help from 'equal colleagues' (P15), that is fellow residents and allied health professionals, as compared to supervisors. This was partly due to their non-involvement in formal assessments (ie less high-stakes). Similarly, residents preferred seeking help from fellow residents and allied health professionals, especially regarding specific clinical practices and 'how the things are done around here' (P9). Other team members sometimes had more useful expertise in clinical practices than supervisors 'if I have any doubts about ultrasounds, I know she [fellow resident] can do better than my supervisor. So then I consult her (…)'(P2). Also, residents talked about asking fellow residents about areas they wanted to improve their knowledge and skills in:

> I invited [fellow resident] once for a physical examination, as I would like to see the joints [the expertise of the fellow resident]. Then we just did it [physical examination] together and then he taught me how to really do it. So I learned a lot from it and it is also just a lot of fun.
>
> (P1)

4 | DISCUSSION

In this study using a sociocultural lens, we explored how residents' help-seeking decision-making processes are being shaped by their workplace environment, including their experiences of the social and cultural practices in the workplace. We found that residents experience asking for help as an act of performance: they perceive the 'how' and 'when' of asking questions, as well as the content of these questions, as a measure of their competence. Moreover, this act of performance was preceded by an internal dialogue in which the need for and potential ramifications of help-seeking were balanced. Residents' sense of responsibility for providing safe and high-quality patient care was the core around which their internal dialogue revolved With this in mind, residents weigh up demonstrating the ability to work independently, maintaining their credibility as a physician and becoming an accepted member of the health care team when seeking help. Residents' internal dialogue was strongly influenced by sociocultural forces of the workplace, including a safe learning environment that was conveyed through a constructive relationship with their supervisors and the approachability of other health care team members. In identifying the complex interplay between the internal balancing act and workplace forces, our study joins a growing body of literature, raising attention for the sociocultural perspective in aiding to unravel the interplay between the social and cultural aspects of residents' learning and clinical practice.[15-19,32]

Framing help-seeking as an act of performance resonates with the literature on how residents perceive the pressure to come across as certain, decisive and independent.[1-3,6,7,19] Residents feel that such attributes are rewarded in performance assessments and, thus, are expected from them during their training towards becoming future medical specialists.[1,19] These pressures are partially embodied by the wide implementation of competency frameworks within medical education with a strong focus on outcomes, competencies and achieving milestones.[33-37] Our study demonstrated how such pressures and expectations influenced residents' internal dialogue, resulting in the unintended consequence of hampering help-seeking. Notably, not posing the less relevant or less clearly worked out questions is potentially problematic as such questions contribute to residents' professional development by providing feedback on knowledge gaps or how to structure their case when presenting a patient.[15] Although residents proclaimed that not seeking help never interfered with providing safe and high-quality patient care, it does raise the question of whether the *most optimal* patient care can always be guaranteed. A previous study reported that patients' treatment could be delayed when residents were uncertain about clinical decisions and did not seek help or input from supervisors.[38] Ultimately, perceiving help-seeking as an act of performance could run counter to residents' learning and potentially the provision of optimal patient care.[6] Hence, our study suggests that to mitigate pressures on residents' internal dialogue, a safe learning environment nurturing the sharing of uncertainty and vulnerability while paying attention to the individual resident and their personal learning needs is imperative.[39,40] In such environments, residents are more likely to speak up and disclose errors partly due to less hierarchy, which may be instrumental for providing safe and high-quality patient care.[41,42]

The fact that residents framed help-seeking as a measure of their competence altered their way of asking questions: they tailored the 'right' way of help-seeking, to the 'right' supervisor or to the 'right' health care team member. By performing questions in that way, residents could more easily access opportunities to demonstrate their

ability to work independently (eg being granted to perform a surgical procedure), safeguard their credibility as a physician and secure a position as an accepted team member. Various studies described how supervisors greatly vary in their supervisory preferences[43,44] and how through tailoring processes (eg altering questions), a shared interaction pattern could be created between residents and supervisors.[44,45] While our results point to similar processes, we also highlighted how residents actively develop their understanding of supervisors' preferences, partially through 'checking' the validity and legitimacy of their questions with other health care team members before asking supervisors. This resonates with Goffman's theory of impression management. He describes how we try to understand what is expected from us during social interactions and then use these insights to influence the perceptions others may hold about us.[46] He described that performance arises in two contexts: in the frontstage where 'some aspects of the activity are expressively accentuated and other aspects, which might discredit the fostered impression, are suppressed',[46] whereas in the backstage 'the suppressed facts make an appearance'.[46] Previous research on feedback conversations suggested how residents wanted to create a front stage performance to display confidence to supervisors.[47] While our results underline this finding, we also provide insights into the interplay between the frontstage and backstage. Residents 'rehearse' their performance of asking questions in the backstage on professionals within the perceived same scope of practice (eg allied health professionals or fellow residents), before asking their questions to supervisors in the frontstage. In that way, residents could manage their impression as they had more certainty that their question aligned with the expected level of independence, and they could portray themselves as a competent (future) colleague, promoting a positive assessment.[36]

Moreover, we also shed light on how help-seeking as performance does not only occur in the presence of supervisors but also how allied health professionals and fellow residents played a key role in residents' decision-making processes to seek help. Our study suggests that while supervisors seemed to be the *gatekeepers* of the medical community, other members within the health care team might serve as *guides* providing practical knowledge and enculturating them into the clinical workplace.[11,12,17,20,26,48,49] Compared to supervisors, other co-workers afforded the 'know-how' of and guided them through the local norms and practices of the particular workplace.[17,20,50] This knowledge is an essential part of socialisation into the health care team[51] as it helped residents to understand and secure their position as an accepted, legitimate team member. The metaphor of asking questions as 'exchanging currency'[52,53] is useful to understand how—by asking for help as performance—residents secure their position within the team. Residents pay by asking for the 'right' help and by forging relationships through actively involving members of the health care team in the delivery of patient care. Residents realised that these communication skills are highly valued by team members.[54] In return, residents are 'paid' by being seen as a credible physician and legitimate team member by health care team members. Studies identified the importance of residents actively engaging and building relationships with all health care team members as more learning opportunities were afforded them[17] and to better ensure patient safety.[55]

4.1 | Implications for practice and research

As our results indicate, it is imperative to create a learning environment in which help-seeking is normalised and seen as intrinsically linked with providing safe patient care and the development as a learner. Addressing potential barriers related to help-seeking decisions should, therefore, be addressed on different levels. Supervisors could address residents' credibility concerns[40,56] by having regular conversations with them about expectations regarding residents' level of training and when they should seek help.[43,44] Furthermore, given the important role of other (non-physician) health care team members in lowering the threshold for residents to ask for help, both formal and informal feedback conversations with fellow residents and allied health professionals could be actively stimulated in training programmes. Such conversations could aid in clarifying role expectations among team members[17] and foreground the shared purpose of patient care,[57] which might help to create a constructive learning environment. This might also support the view that help-seeking is not seen as a potential threat for residents' credibility, but as confirming the team's shared purpose of providing safe patient care. Future research should address how to foster learning environments in which the health care team's shared purpose of safe patient care trumps residents' concerns of negative assessments. We encourage other researchers to consider adopting a perspective that views all health care team members to influence workplace learning interactions.[17,20,21,26,50] Hereto, sociocultural theories can offer guidance.[9-12] We agree with colleagues that such an inclusive perspective may result in a more in-depth understanding of residents' help-seeking decisions and workplace learning in general.[18,32] Finally, although not the aim of our study, we came across some differences in how junior and senior residents weigh up their decisions to seek help. For instance, in how they dealt with demonstrating the ability to work independently. We feel this could be further explored in future research.

4.2 | Strengths and limitations

In unravelling the process by which residents decide to seek help and what shaped this process, our study's strength was adopting the lens of sociocultural learning theories using constructivist grounded theory methodology. It enabled us to construct a model reflecting residents' perceptions of their decisions to seek help and how it played out in the workplace. Simultaneously we acknowledge that the results of this study are constructed based on a combination of the answers of the participants as well as the backgrounds of members of the research team and our use of sociocultural learning theories to understand the results. Our results should be considered

within certain limitations.[58] Since not asking for help may have negative consequences for the quality of patient care and patient safety, residents may have responded in a socially desirable way to the interview questions. In this research, we tried to minimise this bias by using similar but less pejorative terms for help-seeking (eg 'checking'). Moreover, as the interview proceeded, we acknowledged the sensitivity around help-seeking and invited residents explicitly to reflect on this. Data collection took place in only one Academic Medical Center in the Netherlands, which could limit our findings' transferability. However, like in other countries, residency training in the Netherlands is built upon a competency-based framework with generally the same characteristics among countries. Therefore, how residents framed help-seeking as performance, their considerations and, the workplace' influences might be relevant to other training programmes grounded on CBME. Furthermore, the majority of our participants was female. Although this is an accurate representation of the male-female balance within Dutch postgraduate medical education, and our participants did not discuss gender aspects, future research might focus on the gender dimension within the balancing act and how the workplace environment might react differently to requests of help by female residents as compared to male residents.

5 | CONCLUSION

This study suggests that sociocultural forces of the workplace highly influence how residents balance their considerations of whether or not to seek help and the extent to which they frame help-seeking as an act of performance. To lower the barriers for residents to seek help, a safe learning environment resulting from constructive relationships with supervisors and the perceived approachability of fellow residents and allied health professionals seems crucial. We recommend addressing the potential barriers in dialogue with all members of the health care team as they are all tied into residents' help-seeking decisions. Future research could examine how to foster learning environments in which the health care team's shared purpose of safe patient care, trumps residents' concerns of negative assessments.

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CONFLICT OF INTEREST

We have no competing interests to declare.

AUTHOR CONTRIBUTIONS

IJ collected, analyzed, and interpreted the data; wrote the first draft of the manuscript and revised the manuscript after feedback from all other authors. RS and MS contributed to the analysis and interpretation of the data and critically reviewed and revised the manuscript several times. KL participated in data interpretation and reviewed and revised the manuscript several times. All authors are responsible for the design of the research, approved the final version of the manuscript, and agree to be accountable for all aspects of the work.

ETHICAL APPROVAL

The institutional ethical review board of the Amsterdam UMC of the University of Amsterdam provided a waiver declaring the Medical Research Involving Human Subjects Act (WMO) did not apply to the current study (reference number W18_374 # 18.428).

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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