ORIGINAL ARTICLE

Peer coaching in a rural setting: A feasibility study

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Abstract

Introduction: Peer coaching has gained traction as a method for enhancing practical and personal skills without the hierarchical dynamic sometimes found in mentorship. It creates a collaborative environment, encourages inclusivity and community building, and supports skill development across various disciplines and levels of experience. The objective of our study was to assess the feasibility, satisfaction, and effects of a reciprocal peer coaching pilot program for practising physicians in Northern Ontario's remote and rural regions.

Methods: Participants completed 'Peer coaching in practice' micromodules from The Royal College of Physicians and Surgeons of Canada and attended an in-person demonstration. Each participant committed to 2 sessions as both coach and coachee with a self-selected partner. Feedback was gathered at each study interval.

Results: Our qualitative study found that peer coaching positively impacted physicians' daily habits, wellness, and professional growth. The study emphasised the importance of cohesive partnerships in peer coaching and highlighted substantial benefits for both coaches and coachees. The feasibility of peer coaching was a key finding, demonstrating its potential to build supportive communities, particularly for providers in remote areas. While in-person interaction was preferred, the study also acknowledged the potential of virtual coaching, which could benefit providers isolated by geography, demographics, or practice modality.

Conclusion: Peer coaching is an alternative, novel form of continuing medical education and knowledge exchange. It is particularly relevant in rural communities offering crucial support to local providers, especially those in rural or isolated areas where access to formal continued medical education is limited. Our results suggest that peer coaching can significantly improve the daily practices and overall well-being of physicians.

Keywords: Feasibility, peer coaching, rural

Résumé

Introduction: Le coaching entre pairs s'est imposé comme une méthode permettant d'améliorer les compétences pratiques et personnelles sans la dynamique hiérarchique que l'on retrouve parfois dans le mentorat. Il crée un environnement collaboratif, favorise l'inclusion et le développement communautaire, tout en soutenant le développement des compétences dans diverses disciplines et à différents niveaux d'expérience. L'objectif de cette étude était d'évaluer la faisabilité, la satisfaction et

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les effets d'un programme pilote de coaching réciproque entre pairs destiné aux médecins en exercice dans les régions rurales et isolées du nord de l'Ontario.
Méthodes: Les participants ont suivi les micromodules " Expérience Coaching entre pairs " du Collège royal des médecins et chirurgiens du Canada et ont assisté à une démonstration en personne. Chaque participant s'est engagé à participer à deux séances en tant que coach et aidé (e) avec un partenaire de son choix. Des commentaires ont été recueillis à chaque intervalle de l'étude.
Résultats: Notre étude qualitative a révélé que le coaching entre pairs avait un impact positif sur les habitudes quotidiennes, le bien-être et le développement professionnel des médecins. Elle a souligné l'importance de partenariats solides dans le cadre du coaching entre pairs et a mis en évidence des avantages substantiels tant pour les coachs que pour les aidés. La faisabilité du coaching entre pairs a été une conclusion clé, démontrant son potentiel pour créer des communautés solidaires, en particulier pour les prestataires de soins dans les zones isolées. Bien que les interactions en personne aient été préférées, l'étude a également reconnu le potentiel du coaching virtuel qui pourrait bénéficier aux prestataires isolés par la géographie, la démographie ou leur mode d'exercice.
Conclusion: Le coaching entre pairs est une forme alternative et novatrice de formation médicale continue et d'échange de connaissances. Il est particulièrement pertinent dans les communautés rurales où il offre un soutien crucial aux prestataires locaux, en particulier ceux des zones rurales ou isolées où l'accès à une formation médicale continue formelle est limité. Nos résultats suggèrent que le coaching entre pairs peut améliorer considérablement les pratiques quotidiennes et le bien-être général des médecins.

Mots-clés: Coaching entre pairs, Rural, Faisabilité

INTRODUCTION

Medical education has always been based on an apprenticeship model. Undergraduate learners (mentees) typically work with senior and experienced practitioners (mentors) to develop their clinical skills and strengthen their academic knowledge.[1,2] This relationship helps familiarise mentees with community practices and administrative tasks and optimises new or infrequently practised skills.

Peer coaching, on the other hand, fosters a collaborative environment by not establishing the senior/junior relationship present in mentorship, although both aim to support recipients. This collaborative nature supports the foundation of deliberate practice, which is essential in developing expertise across numerous disciplines.[3,4]

Peer coaching is a modality that has gained a growing interest for improving practical and personal skills such as surgical procedures, managing learners with difficulty, and improving communication with patients and colleagues.[3,4] Peer coaching is a moderately structured process that enables experienced providers to support colleagues in identifying solutions to their questions, thereby fostering a sense of inclusion and community.

Peer coaching typically requires less time commitment, is less structured, and supports open discussion without the power relationship associated with the apprenticeship model.[5-7] Peer coaching topics can be specific for early career physicians, marginalised or underrepresented participants, and may include resident learners.[5,6,8] Peer coaching is historically common in surgical practice, although it was not always identified as such, where experienced staff supports the acquisition of new skills in novice colleagues.[1] Peer coaching programs are predominantly done in person.[9-11] However, digital and virtual technology use increased throughout the COVID-19 pandemic.[11] Virtual opportunities facilitate coaching for physicians who may live in remote communities or prefer support outside of their medical community.[6,12] Topics may include, but are not limited to, emotional support, patient advocacy, governance structure, practical advice or integration of research into routine practices.[6]

What is unique about peer coaching is that it supports self-disclosure in a safe environment, allowing colleagues to communicate openly, without judgement.[6] Supportive work environments are directly related to reduced physician burnout and increased physician retention.[13] Peer coaching has been shown to improve knowledge acquisition and retention and skill development with high participant satisfaction.[1,9] However, peer coaching is traditionally initiated at senior levels of organisations and within academic centres, seldom including rural or remote faculty who

are geographically or ethnically isolated. Peer coaching supports continued self-improvement, medical education and skill development.[9,10,13]

Continuing medical education (CME) is a requirement in most countries. However, most CME requires practitioners to attend conferences away from their practice, read articles, watch videos or take additional coursework. Peer coaching supports adult learning theories through practice, goal setting, reflection and critical analyses in real time. It facilitates and reinforces personal reflection in a supportive environment.[13]

While studies confirm peer coaching benefits the coach and the coachee in various ways, data regarding rural communities are absent.[12]

This study was designed to evaluate the feasibility of, satisfaction with and implications for the practice of a reciprocal peer coaching pilot program for practising physicians in various career stages in remote and rural areas of Northern Ontario.

METHODS

Research personnel from the Huntsville Physicians, South Muskoka and Parry Sound Local Education Groups coordinated this single cohort prospective longitudinal study.

Participants included the faculty of the Northern Ontario School of Medicine University. Invitations were sent by E-mail through the Local Education Group administrative staff and snowball sampling among peers. All participants completed an informed consent before the start of the study. Each participant was provided with a research ID following consent to link surveys and feedback while ensuring participant anonymity. Coaching pairs were matched by mutual agreement, personal goals and experience; they were required to communicate verbally and have identified learning goals (technical or non-technical) that could reasonably be expected to be met through coaching interactions with their partner. In other words, they were to coach each other. Partners self-selected at the in-person workshop based on pre-existing relationships, experience and expertise of the partner and relatable goals. Each partner had to agree to the pairing before the pairs were confirmed. Members of each pair did not need to be from the same speciality or geographic region.

Before the training sessions, participants completed an online baseline questionnaire regarding their attitudes towards reciprocal peer coaching, their expectations about this intervention and a demographic questionnaire.

All participants were given access to the 'Peer coaching in practice' micromodules from The Royal College of Physicians and Surgeons of Canada. Completion of these modules (6 modules, each 10 min in length) was required before the coaching workshop. The coaching workshop, which was an in-person event at a local facility, included a coaching instructor who demonstrated a coaching session and allowed participants to practice, familiarise themselves and delve further into coaching skills and practices. Participants openly discussed their coaching needs and/or goals, which facilitated the natural pairing of partners before the workshop was complete. All participants were offered an orientation to the Zoom platform (zoom. com) to facilitate their coaching sessions if face-to-face meetings were not feasible.

Each participant committed to 4 coaching sessions, 2 as the coach and 2 as the coachee. These sessions occurred virtually or in person and were scheduled for at least 30 min each (more if required – no hard stop time). Coaching sessions were anonymous to the researchers, and information shared within a coaching session was not shared for study purposes. Partners were instructed to discuss their individual goals, fears, concerns and areas they wished to focus on during the sessions. Eligible participants' topics could be subject oriented (i.e. provision of MAID), administrative (i.e. tips to adhere to a clinical schedule – time management with patients) or medico-legal (i.e. dealing with addiction treatment and prescribing), among others identified by participants. The coaching sessions were to be completed within 9 months of the initial training. Pre- and post-intervention survey responses were collected prior to, immediately after and 9 months following the initial coaching workshop.

The post-intervention questionnaire explored the impact of the coaching interventions on the physicians' practices, the usefulness of the experience compared to other continuing professional development (CPD) activities and the impact of the exchange on their relationship with their partner.

Two independent reviewers analysed qualitative data according to the grounded theory methodology. Inferential *t*-tests were

used to examine differences in pre- and post-interventional responses between males and females, between respondents who had been in practice for 9 or fewer years and 10 or more years or between Family Medicine Specialists and all other Specialists.

RESULTS

Thirty-two physicians confirmed an interest in participating, including representatives from each community. Participants included those with specialised practice (e.g., surgery, internal medicine, physiatry and emergency medicine) and primary care providers. A total of 22 participants completed all the requirements for this study, equally represented by male and female participants. Respondents primarily practised family medicine (53%), with others specialising in surgery, emergency medicine, gastroenterology, internal medicine and physiatry. Thirty-five per cent of respondents were in practice for <10 years, and 63% were in practice for 10 or more years. Four respondents (18%) had previously experienced peer coaching, while 15 (68%) had experienced mentorship.

There were no statistical differences in pre- and post-interventional responses between males and females, between those who had been in practice for <10 years and those who had been in practice for 10 or more years. However, there was a trend for more inexperienced participants to be concerned about their reputation and professional acceptance when discussing personal areas of difficulty.

Qualitative analyses

Responses were collected for 7 questions related to the pre- and post-intervention coaching experiences. Using the grounded theory, common themes were identified by respondents about their experience with peer coaching.

Participants explored *wellness and professional growth* through the reflective and supported nature of peer coaching. Participants were asked to comment on various aspects of the need for peer coaching, how the coaching impacted them, it's relevance and applicability in the rural setting and how the experience impacted their practice. They indicated a goal to enhance their skills as coaches, emphasising the self-directed aspect of coaching. It was also noted that coaching skills should be reciprocal and standard for all physicians.

'Anxiety was alleviated, having completed the interaction',

'Learning how to create a safe space for discussion and explore situations non-judgmentally is a life skill!',

'In a time of high physician burnout I think most of us would recognize the value in peer coaching',

'The benefit is hard to perceive at the front end, but it does improve communication and team building as well as emotional health'.

The role of coaching was found to be effective in *fostering a supportive network and community.* Participants were asked about the reproducibility of this programme, the impact on their established relationships and their feelings about coaching after participating.

'Peer coaching promises to become a very enjoyable and efficient way to achieve this goal and foster the connections to my colleagues and peers'.

'I appreciated the opportunity to work alongside my colleagues. I felt supported'.

'We could all use some help and help others'

'It is important to feel supported emotionally and socially in a community'.

In developing a community of support, participants were asked how this peer coaching compared to more traditional forms of CME and indicated that adapting this type of coaching programme to *meet the needs of participants and the local context* is essential for its success. The opportunity to receive CME in the community relevant to practitioners and community health was noted to be of significant value.

'Rural peer coaching has the distinct advantage of providing assistance in the setting (or equivalent) in which the need has arisen'.

'This type of peer coaching could be implemented in virtually any workplace, not only medicine. Although, with the current strains on our medical system and its health care providers, it is particularly valuable in medicine',

'The program is quite adaptable'.

Peer coaching *enhanced participant learning and engagement* and was perceived to be a more interactive, relevant and effective method of

professional development compared to traditional CME opportunities. While CME is required in medical practice, many options lack hands-on practice, require travel and require time away from family and clients. A significant number of respondents appreciated the relevance to their practice, community and patients of peer coaching.

'Adult learning, to me, is comprised of presentation of information or a skill followed by an opportunity to apply the information or skill to allow consolidation of the information or skill. This modality supplied information to review before meeting and instruction from the expert, followed by an immediate opportunity to apply the knowledge and skills, followed by a consolidation period over months'.

'More engaging, ability to form relationships and bond with peers'.

When asked about the universality of a program such as this, peer coaching was reported as an effective medium for *mutual knowledge exchange* and CPD, which may be highly relevant to the growth of newer medical schools.

'As NOSM U expands we will have a lot of colleagues who will need our coaching as they assume greater roles in medical education',

'Excellent opportunity to meet and exchange knowledge and experience',

'I think we will be able to draw experiences from our colleagues'.

Coaching was also reported as directly applicable and valuable *as daily CME*. Coaching not only expands personal knowledge and skills but also establishes and supports collegial communication and support.

'This is a unique skills area that I don't think I have come across any CME for previously', 'More relevant and engaging',

'Peer teaching (sic) in our community will be much better than traditional CME as it will recognize our context and our current strengths and weaknesses'.

Participants expressed a desire to enhance their skills as coaches, underlining the self-directed aspect of peer coaching. In rural communities, physicians are at various stages of their careers. Coaching can be an effective learning strategy for all levels of expertise, for physicians who often have skills in different areas based on when they received their training, what additional education they have pursued and what their practice focuses on.

'Peer coaching seems to be a more efficient and enjoyable way of teaching towards becoming an excellent physician',

'I think we can all benefit from learning how to coach our physician colleagues at various stages of their careers',

'I would consider it a form of emotional intelligence, which is as important as intellect in my opinion'.

Respondents also highlighted how peer coaching enhanced collaborative practices among physicians. Collaborative practice and effective communication were noted as necessary in *improving patient care* and establishing a more cohesive, positive, work environment.

'As a newly practicing family physician, collegiality amongst my colleagues is a tool that can greatly improve my day-to-day function both clinically and professionally', 'Coaching skills such as helping people find their own answers as well as supporting colleagues beyond any agenda other than ensuring they act with integrity and according to their own values and core beliefs are much needed in medicine'.

Rural physicians have different *practice needs and demands* than their urban counterparts. Coaching that provides support specific to this environment was reported to be closely aligned with physicians' practical needs, enhancing the immediate applicability of these skills.

'Local solution to local issues',

'beneficial for health care professionals of all levels of experience',

Peer coaching was also found to positively *impact physicians' daily practice habits* through increased communication and knowledge sharing, thus improving their confidence. Rural physicians can feel isolated and reluctant to ask for help or reveal their challenges, particularly in smaller communities. Participating in peer coaching can motivate and engage physicians, offering collegial support, which can be accomplished in person or through hybrid technology.

'It was a reminder to listen more actively without wanting to jump in and offer solutions or suggestions',

'I am better at discussing issues with colleagues',

'I feel comfortable asking for help and not be labelled as 'weak'.

'In a rural community it is easy to feel isolated so knowing that a peer is officially there for you if needed would be a comfort for most'.

Challenges to successful peer coaching programs were noted, including time constraints currently facing medical professionals and ensuring a good match between the coach and coachee. Suggestions were made to compensate for participation and offer protected time for those interested in participating.

'Finding the right coach-coachee relationship will be key',

'Anything that requires time is challenging to implement',

'The only issue might be time constraints'.

DISCUSSION

Peer coaching programmes aim to develop relationships within peer groups that allow the coach and the coachee to expand their knowledge and skills while fostering a supportive work environment.[1] Peer coaching may begin through organic, informal interactions that become essential in providing social and professional support in times of need. By establishing trusted interactions and peer relationships, physicians experience better camaraderie. These physicians are more supported in professional and personal challenges, positively impacting physicians' well-being and reducing burnout.[13,14]

Cross-disciplinary peer coaching can be particularly supportive in developing relationships to establish collaborations for academic and research purposes.[5,6] Peer coaching can be implemented in regular small group meetings or as a one-to-one experience.[12] It is associated with increased physician retention, research interest and publications.[12] Formalised feedback to help the coachee meet self-defined goals distinguishes peer coaching from mentoring (the apprenticeship model), which involves informal advice without specific goals in mind.[14] Peer coaching differs from mentorship programmes in that it can reduce the time commitment, has fewer power differentials and increases the alignment of goals.[7] Peer coaching facilitates the transfer of knowledge and skills into the workplace, improving experience, skills and attitude.[5]

There exists minimal research on the impact of peer coaching across different practices and even less in rural communities.[13] To our knowledge, this study is the first of its kind to report how meaningful peer coaching can be in supporting rural providers academically, intellectually and personally.

Our study found that peer coaching was easily facilitated, supported wellness and professional growth and met the local physician community's needs while developing a supportive network for them. It was noted that learning about and incorporating peer coaching into their routine was accessible and more effective than many other CME options. Having the opportunity to interact with a peer coach positively impacted self-perceived physician communication and interactions with patients and colleagues and was reported to reduce feelings of physician burnout. Barriers exist for peer coaching, most notably time, followed by ensuring an appropriate coach/coachee match, which others have recognised.[1,13]

Qualitative findings reported elsewhere and confirmed in our study demonstrate substantial benefits for both the coach and coachee in an array of areas.[13] Establishing a community of support can reduce provider burnout and improve job satisfaction, which in turn may lead to better quality of life and patient care.

Limitations

This study included physicians with diverse practice focus who lived across a vast geography. While the methodology was sound and included pre- and post-questionnaires with long-term follow-up, our results are related to this group of physicians and may not extrapolate similarly to other communities. More research needs to be completed to inform people about the long-term benefits of coaching and its transferability to other areas.

CONCLUSION

Peer coaching is an alternative, novel form of continuing medical education and knowledge exchange. It is particularly relevant in rural communities offering crucial support to local providers, especially those in rural or isolated areas where access to formal continued medical

education is limited. Our results suggest that peer coaching can significantly improve the daily practices and overall well-being of physicians.

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