ORIGINAL ARTICLE

Informal peer support for rural doctors

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Abstract

Introduction: Practising medicine exposes physicians to emotionally difficult situations, which can be devastating, and for which they might be unprepared. Informal peer support has been recognised as helpful, although this phenomenon is understudied. Hence, it is important to develop a better understanding of the features of helpful informal peer support from the experiences of physicians who have successfully moved through such difficult events. This could lead to new and potentially more effective ways to support struggling physicians.

Methods: Rural Canadian generalist physicians were interviewed. Using a hermeneutic phenomenological approach, data analysis was oriented towards understanding features of helpful informal peer support and the meanings that participants derived from the experience.

Results: Eleven rural generalist physicians took part. Peer support prompted the processing of difficult emotional experiences, which initially seemed insurmountable and career-ending. Participants overcame feelings of emotional distress after even brief encounters of informal peer support. Most participants described the support they received as *vitally important*. After the peer support encounter, practitioners no longer thought of leaving medical practice and felt more able to handle such difficulties moving forward.

Conclusions: Informal peer support enabled recipients to move through an emotionally difficult experience. Empathy, shared vulnerability and connection were the part of the peer support encounter. In addition, the support offered benefits which are known to help physicians not only process emotionally difficult events but also to acquire 'post-traumatic growth'. Practitioners, healthcare leaders and medical educators all have roles to play in enabling the conditions for informal peer support to flourish.

Keywords: Informal peer support, qualitative research, rural medicine

Résumé

Introduction: La pratique de la médecine expose les médecins à des situations émotionnellement difficiles, qui peuvent être dévastatrices, et auxquelles ils ne sont pas préparés. Le soutien informel par les pairs a été reconnu comme utile, même si ce phénomène est peu étudié. Il est donc important de mieux comprendre les caractéristiques du soutien informel par les pairs à partir des expériences de médecins qui ont réussi à traverser des événements aussi

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difficiles. Cela pourrait conduire à de nouvelles façons, potentiellement plus efficaces, de soutenir les médecins en difficulté.
Méthodes: Onze médecins généralistes canadiens ruraux ont été interrogés. En utilisant une approche phénoménologique herméneutique, l'analyse des données a été orientée vers la compréhension des caractéristiques du soutien informel utile par les pairs et des significations que les participants ont tirées de l'expérience.
Résultats: Le soutien des pairs a incité à vivre des expériences émotionnelles difficiles, qui semblaient au départ insurmontables et mettant fin à une carrière. Les participants ont surmonté leurs sentiments de détresse émotionnelle après même de brèves rencontres de soutien informel par leurs pairs. La plupart des participants ont décrit le soutien qu'ils ont reçu comme étant d'une importance vitale. Après la rencontre de soutien par les pairs, les praticiens ne pensaient plus à quitter la pratique médicale et SE sentaient plus capables de faire face à de telles difficultés à l'avenir.
Conclusion: Le soutien informel par les pairs a permis aux bénéficiaires de traverser une expérience émotionnellement difficile. L'empathie, la vulnérabilité partagée et la connexion faisaient partie de la rencontre de soutien par les pairs. En outre, le soutien a offert des avantages connus pour aider les médecins non-seulement à gérer des événements émotionnellement difficiles, mais également à acquérir une 'croissance post-traumatique'. Les praticiens, les dirigeants des soins de santé et les enseignants en médecine ont tous un rôle à jouer pour permettre aux conditions propices au soutien informel par les pairs de s'épanouir.

Mots-clés: Soutien informel par les pairs, médecine rurale, recherche qualitative

INTRODUCTION

Practising medicine, by its nature, creates emotionally difficult situations for physicians. Adverse events, medical errors, complaints and malpractice lawsuits are recognised as particularly challenging events for practitioners to cope with and commonly result in emotions such as shame, guilt, shock, fear and pain.[1-5] 'While these events are, to some degree, an inescapable part of the medical profession, conventional training does not address their potentially devastating emotional impact on healthcare providers',[5] nor offer a pathway for practitioners to navigate such experiences.

Previous research has described health professionals as the 'secondary victims' of medical error, adverse patient outcomes and other difficult events and has identified a range of significant emotional and psychological repercussions arising from this experience, including chaos and response, intrusive reflections, restoring personal integrity, enduring the inquisition, obtaining emotional first aid and moving on.[2] Affected practitioners are known to experience long-term effects from these experiences, described as dropping out, surviving or thriving.[2] As yet our understanding of coping strategies and supports for affected providers is incomplete.[4] It is important to develop a better understanding of the experiences of physicians who have successfully moved through such difficult events.

Rural practitioners are perhaps more vulnerable than their urban counterparts to these experiences. Rural physicians are at times called to practise outside of their usual scope of practice, to provide essential medical care to patients in need when access to specialist care is not available in a timely fashion.[6] This 'clinical courage' is seen as part of the practice of rural medicine, in which practitioners make a 'deliberated altruistic decision to put themselves into positions where they will feel out of their depth clinically and risk distress, professional isolation and potentially psychological trauma' to serve their patients.[6] Clinical courage is facilitated by local medical team relationships, especially the help of skilled doctors, nurses and paramedics. Other trusted rural doctors, who are part of the rural physician's own network, may also provide support for the ongoing practice of clinical courage.[7]

Physicians who experience emotionally difficult situations desire peer support, that is, assistance, comfort and encouragement to keep going.[2,5] Research suggests that peers are regarded by affected physicians as the most desirable source of support[5,8,9] and particularly a peer of equal standing and with insight into the situation.[10] However, physicians may be unable or unwilling to access adequate peer

support.[5] Concern about stigma and negative career repercussions prevent practitioners from reaching out.[5] Elements of medical culture, such as the conspiracy of silence, the culture of blame and the tendency to ignore distress, pose challenges for physicians to both appreciate and address their suffering.[11] In an attempt to bridge this gap between need and accessibility, there is a growing call for organisations to develop formal peer support programmes.[12-14] While these programmes are welcomed, informal peer support (that which arose spontaneously, outside of an organised support programme) may offer unique advantages.

Although informal peer support may not be widely available, some physicians do access it. Yet, there has been little work done to understand the experience of those who have engaged in it. Informal peer support has the potential to be a helpful, low-cost and potentially easily available intervention. Our research looked at understanding the features of effective informal peer support, and how it arises, which could lead to potentially more effective ways of supporting struggling physicians.

METHODS

Methodology

We adopted a hermeneutic phenomenological approach, as we sought to both describe and advance understandings of helpful informal peer support from studying participants' lived experiences and the meaning they attribute to those experiences.[15,16] Phenomenology seeks to describe lived experiences,[17] whereas hermeneutics is the study of knowledge and knowing through interpretation and holds that researchers naturally bring their own experiences and knowledge to a research project.[16] Hermeneutics adds a layer of interpretation of meanings that moves the findings beyond the immediacy of the lived experience.

In hermeneutic phenomenology, the researchers bring their own 'horizons' to the research by reflecting on the meanings attributed to the experience resulting (metaphorically speaking) in a fusion of horizons – that of the researchers and the participants, thus enabling new insights to be developed.[18] The first and second authors are longstanding and committed rural physicians with experience in supporting the well-being of rural practitioners and thus are well positioned to bring their understanding of those contexts to the research process. The third author is an outsider to the community – an experienced medical education researcher.

Participants

Participants were a purposive sample of Canadian rural physicians who self-identified as having had a positive experience of engaging with informal support from a peer, in relation to a work-related stressor. Those with a positive experience of informal peer support were chosen because they could tell us about the phenomenon. Participants were recruited through e-mail and distributed through the first author's professional contacts.

Data collection

Individual, virtual semi-structured interviews of 1 h duration were conducted by the first author. The interview questions focused on the experiences of informal peer support, the conditions and context under which the peer support arose, and the meaning that participants constructed of the experience and for their career. Interviews were recorded and transcribed. Field notes, consisting of observations, emotional reactions and reflections, were generated by the first author after each interview.

Data analysis

Hermeneutic phenomenology data analysis involved the following stages: immersion, understanding, abstraction, synthesis and theme development, illumination and illustration of phenomena and integration and critique of findings.[16] The research team immersed in the data by reflecting both individually and then together on the transcripts, the coding and the reflective notes of the early interviews. Initial team discussions sought to develop codes and a preliminary understanding of the data. The transcribed interviews were coded by the principal investigator using NVivo software (Lumivero, Denver Colorado, USA). As the data collection proceeded, discussions moved towards a more abstracted view of the material,

guided by the hermeneutic circle.[16] This metaphor for understanding and interpretation is viewed as a movement between parts (data) and whole (evolving understanding of the phenomenon), each giving meaning to the other such that understanding is circular and iterative.[16] Thus, the team discussed their interpretations of the collective experiences of informal peer support in relation to an individual participant's experiences and the team's own evolving understandings, moving between individual stories and collective to identify the feature of helpful informal peer support.

Ethical approval

Ethical approval for the research was obtained from the University of British Columbia's Behavioural Research Ethics Board.

RESULTS

Eleven physicians from across Canada volunteered to participate. The nine women and two men ranged from 35 to 65 years of age, with between 7 and 39 years of medical practice experience. All participants were Canadian rural family physicians with a 'generalist' scope of practice, involving one or more of emergency medicine, obstetrical or hospitalist duties in addition to outpatient clinic services. All physicians worked in communities where they were the sole provider on call when covering a hospital service, and the majority had no access to specialists within the community. Some practitioners worked in extremely remote settings.

Eight participants reported critically ill patient encounters, one reported a surgical complication and one had an event related to clinic administration. One participant described ongoing gender discrimination as the stressor. For all participants, these experiences were emotionally laden, troublesome and severe.

Participants reported feeling overwhelmed, inadequate, shocked, responsible, isolated, incompetent, clumsy, in terrible pain and like a failure. Most participants questioned their competency and abilities and believed that they were flawed. Many participants described wanting to quit medical practice. Participants in this study commonly described feelings of shame but did not actually use the word. Shame is 'an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging'.[19] This definition by experienced shame researcher Brene Brown aligns well with what participants were describing and also with the lived experience of the physician authors. Shame is not the awareness of having done something wrong, but the experience of feeling wrong as an entire person, as described in the following quote:

> 'At the time, I definitely was having lots of thoughts of, like, "I'm bad at my job. How could I have done that?" A lot of thinking of "What did I do wrong?" You know, I went back and looked at the chart and thought…' Did I listen to her lungs or not? Maybe I didn't listen to her lungs. Oh my God, what if I didn't listen to her lungs?' (Participant 8, 35-year-old woman).

The peer support encounter most commonly arose because *the peer reached out* and inquired about the emotional well-being of the participant. Peers often had an awareness of the emotional distress of the participant because of physical proximity and initiated a conversation by asking simple questions about well-being. Peers who were not co-located were also valuable sources of support. On these occasions, a general inquiry about well-being was an opening that led to a deeper conversation.

> 'I was able to just put my head down on the desk and, you know, shortly after somebody stood up and walked over and put her hand on my back and said, "Oh, are you okay?" and sat and pulled up a chair and said, "What's happening?" And so, you know, that was huge' (Participant 5, 47-year-old woman).

Two participants reached out for emotional support. For one participant, her previous experience of receiving peer support gave her a new understanding of its importance, and she was intentional about seeking it on a subsequent occasion.

All participants received support from a peer with whom they had a pre-existing relationship, although not necessarily one with any emotional closeness. Peers were described as approachable, genuine, warm, loveable, positive, trustworthy and caring.

Most instances of support were brief. Conversations were often 5–10 min in duration. Conversations mostly took place in person or over the phone, but brief e-mails and texts of support were also considered valuable. A few peer support interactions involved a lengthy conversation or took place over multiple interactions. Five participants had conversations with multiple peers, all of whom were aware of the precipitating event because of proximity. This encounter is striking in its brevity:

> 'And (the specialist) texts me and he said, "Hey, keep your head up. It happened to me last January". And that's the only thing that he ever said to me about it. And it was – It was very, very helpful. It actually changed the course of the day for me for him just to say that' (Participant 2, 53-year-old man).

Participants described several features of the encounter that were valuable to them. They greatly appreciated a non-judgmental attitude and a peer who listened well. One participant described the peer as 'somebody who saw it with my eyes' (Participant 6, 62-year-old woman). Another said:

> 'She listened and understood. She did not try to solve anything or, you know, suggest solutions or anything. She was just present' (Participant 3, 47-year-old woman).

Peers were also highly valued for their intimate understanding of the situation, its gravity and the context of rural medicine. Local peers had detailed knowledge of the setting, such as available resources, the skills of the medical personnel involved and sometimes they even knew the patient. Peers who were not co-located also understood working in a resource-limited setting.

When peers shared their own past experiences of distressing events, they shared vulnerabilities and demonstrated the possibility of overcoming such difficulties, which helped participants realise this might be possible for them too. This helped practitioners understand that their experience was not unique and that they were not alone.

> 'What I found really helpful was them saying, "Oh, I've had a complaint. I've been sued. It happens to all of us". It was more of an empathy kind of "That's really hard. I know what you're going through because I've been there" type of response. And just a bit of that perspective about, you know, it's bound to happen in your career. You're not going to get everything right. We don't all get everything right, and it's okay' (Participant 8, 35-year-old woman).

Peers also often reminded participants that they were competent and valued, and this helped participants to reframe the situation, instead of just focusing on their perceived inadequacies.

The meaning participants attached to the support they received was significant given the brevity of the support encounter. The majority of participants described it as *vitally important*, and 5 volunteered that the support was essential to their ability to continue to practise medicine. Even brief conversations with peers helped physicians process shame. After the peer support encounter, practitioners no longer thought of leaving medical practice.

> 'The thing that's really moving to me about that experience is that 23 years later, I wouldn't have had these 23 years here without him in that moment' (Participant 11, 50-year-old woman).
>
> 'I think it's critically important. Like, I don't think I would last in what I do. Honestly, I probably would quit medicine' (Participant 4, 41-year-old woman).

Other perceived benefits of peer support varied by participant, such as 'growing confidence' and 'becoming a stronger person'. Some volunteered that they felt valued and affirmed as a whole person, not only as a physician. They were more likely to ask colleagues for help with clinical difficulties. All participants reported greater acceptance of themselves following peer support, despite self-perceived imperfections. They were more comfortable with the uncertainties of medical practice.

> 'She helped me feel like I was still valuable. That I still made a difference' (Participant 3, 47-year-old woman).

Participants also reported benefits from peer support that had a positive impact on others, including better connections with patients and medical colleagues. One participant reported having more compassion for patients after peer support, in that as a young healthy man he had previously felt invulnerable. Sharing his vulnerable

experience with a peer led to an understanding of how others might also feel vulnerable. Another reported providing better patient care. Some also felt motivated to reach out and support distressed colleagues.

> 'I realised how important those small, little gestures (of support) were to me, so if I can do those small, little gestures for somebody else – Even just to plant the seed of saying, 'I'm noticing you, you matter, you're important', then that might help them move on in their journey too' (Participant 3, 47-year-old woman).

DISCUSSION

Participants in this study described severe distress as a result of a workplace event. The most common precipitating event was a poor patient outcome. Regardless of responsibility, our participants perceived they had made errors in care. Exposure to very ill patients, and the need to care for them, often without the resources dictated by standards of care, is an expected part of rural practise and has been recognised as requiring clinical courage. Rural physicians have an awareness of the need for clinical courage but are perhaps less prepared to deal with the aftermath of such difficult experiences. Our participants, for the most part, did not intentionally seek the support of their colleagues to process the situation, and even seemed unaware that their experiences were not unique. Peer support was provided by a kindly peer who was genuinely interested in their well-being. The peer listened without judgement, provided validation and reframed the participant's perceptions. In sharing personal stories of their own experiences, they helped normalise it as a difficult but expected part of medical practice. Informal peer support enabled participants to move through shame, acquire wisdom and influence medical culture.

Moving through shame

Although most described it, no participants labelled their feelings as shame, suggesting that shame was unrecognised, or perhaps unspeakable, by participants. This is not surprising as the culture of medicine is mostly silent about these experiences. Shame is 'the elephant in the room: something so big and disturbing that we don't even see it, despite the fact that we keep bumping into it'.[20] Physicians may be particularly vulnerable to shame, as shame is associated with perfectionism (a trait common amongst physicians) and is exacerbated by toxic elements of medical culture.[21] Needing to ask for help has also been identified as a shame trigger for practitioners, which may explain reluctance to actively seek support.[22] Shame leads participants to question whether they belong in the profession, a response experienced by the majority of our participants. After a peer support conversation, those participants who had thought of leaving rural medicine no longer felt that they needed to or that they alone were at fault, which is indicative of moving through shame. Empathy, shared vulnerability and connection are antidotes to shame,[21] and all three elements were features of the peer support encounter.

Acquiring wisdom

Beyond surviving a difficult experience, receiving peer support was an opportunity for personal growth, as described by many participants. Informal peer support seems to have offered benefits which are known to help physicians, not only to move through emotionally difficult events, but also to go on to acquire 'post-traumatic growth' or wisdom.[23] This wisdom is facilitated by conversations with peers that are emotionally focused, include a peer who really listened, who acknowledged both the seriousness and emotional impact of the situation, and who helped put it in perspective by conveying that these events are expected experiences in a medical career.[9] Knowing one was not alone was also shown to be helpful, as was accepting personal imperfections. Interestingly, all of these benefits arose from peers with no formal peer support training, but who appear to be deeply intimate with the meaning of the distressing experience and simply reached out. Aspects of informal peer support, such as the source and timing of the support, may be contributing factors.

Shifting medical culture

Informal peer support offers a way to mitigate the toxic elements of medical culture. Peers reached out to initiate support at a time when it was most needed. Peers also signalled a willingness to engage in a difficult topic of conversation, and this helped participants overcome some of the cultural

barriers to meaningful dialogue, such as the culture of silence, the need for perfectionism and the tendency to ignore suffering. Both peer and participant needed to be willing to be vulnerable for the support encounter to take place, creating an encounter outside of usual cultural norms. Each of these small shifts, if successful, increases the likelihood of them happening again, as suggested by participants reporting an intention to reach out to other struggling physicians after receiving peer support themselves.

Implications

The variable nature of the informal peer support encounter, in terms of relationship to the peer, insights of the peer, timing and method of communication and specific support provided, point to the value of informal peer support. Some of these relational and contextual aspects cannot be replicated with formal support programmes.

Expanding the circle of care to include coworkers need not be onerous. Simple questions such as 'How are you feeling?' and 'Are you okay?' can make a big difference to a struggling colleague. Short conversations that may arise from these queries can have significant impacts on recipients. Small offers of support resulted in surprisingly magnified outcomes for recipients. Importantly, our data suggest that the barriers are reduced for future encounters once a participant experiences helpful informal peer support.

Physicians should seek opportunities to reach out to colleagues who seem distressed. Such actions convey an understanding of the importance of emotional support, of the need to address shame and suffering, and the value of compassion. At the very least, peers serve as role models and normalise such conversations within the local medical culture,[21] setting the stage for informal peer support to flourish.

As informal peer support emerges from existing relationships, opportunities for physicians to gather and build connections are helpful. Once a colleague is recognised as kind and safe, peer support becomes possible. Administrative and medical leaders can facilitate this process by being intentional about creating the conditions that cultivate community at work.[24] Medical educators are also well placed to nourish informal peer support. Education on difficult topics such as medical error, vulnerability and shame could bring them out of the darkness and start to normalise such discussions.

Limitations

A limitation of this research is the inclusion of only participants with positive experiences of peer support and recruited through personal contacts. The small sample size may have limited our understanding of the lived experience of peer support, in that a larger sample size may have offered new perspectives not captured in this work. We do not know about the experience of those where an invitation was offered but not taken up or found to be unhelpful. Significantly more women than men took part, which could have skewed results. Furthermore, this study was of rural physicians, which make up only 8% of the physician workforce in Canada.[25] Although the same issues of workplace stressors and medical culture broadly apply, there are likely to be nuances of professional relationships and interactions that are context dependent. There is a need for more research on informal peer support, including exploring the perspective of the providers.

CONCLUSION

The current climate of healthcare, with multiple pressures on healthcare providers, and the attendant adverse consequences for both physicians and patients, requires us to take more action in support of practitioner well-being. Informal peer support enabled recipients to move through an emotionally difficult experience and even offered features which are known to support the acquisition of 'post-traumatic growth'. Informal peer support, with some nurturing, could become a more widely available and effective resource for practitioners. Practitioners, healthcare leaders and medical educators all have roles to play in enabling the conditions under which informal peer support could flourish.

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