Peer Support for Clinicians: A Programmatic Approach

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Abstract

Burnout is plaguing the culture of medicine and is linked to several primary causes including long work hours, increasingly burdensome documentation, and resource constraints. Beyond these, additional emotional stressors for physicians are involvement in an adverse event, especially one that involves a medical error, and malpractice litigation. The authors argue that it is imperative that health care institutions devote resources to programs that support physician well-being and resilience. Doing so after adverse and other emotionally stressful events, such as the death of a colleague or caring for victims of a mass trauma, is crucial as clinicians are often at their most vulnerable during such times. To this end, the Center for Professionalism and Peer Support at Brigham and Women's Hospital redesigned the peer support program in 2009 to provide one-on-one peer support. The peer support program was one of the first of its kind; over 25 national and international programs have been modeled off of it. This Perspective describes the origin, structure, and basic workings of the peer support program, including important components for the peer support conversation (outreach call, invitation/opening, listening, reflecting, reframing, sense-making, coping, closing, and resources/referrals). The authors argue that creating a peer support program is one way forward, away from a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety.

Burnout is plaguing the culture of medicine.[1–3] Characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment, burnout negatively impacts patient care. Studies indicate that as many as one in three physicians experience burnout during the course of their career.[4,5] The literature links burnout to several primary causes including long work hours, increasingly burdensome documentation, and resource constraints.[6,7] Beyond these, an additional risk factor for emotional stress, isolation, and burnout is involvement in an adverse event, especially one that involves a medical error.[8–10]

Involvement in an adverse event, especially due to a medical error, can be devastating for physicians. Not only is the culture of medicine one of high standards and perfectionism, it is also one in which emotional reactions to adverse events are generally not acknowledged or openly discussed. This environment leaves physicians highly vulnerable. Common reactions of physicians involved in adverse events include sadness, shame, fear, and isolation.[9,10] Left unaddressed, these emotional reactions can be devastating—potentially leading to depression, anxiety, burnout, and even suicide.[1] Such fallout may negatively impact clinicians, teams, institutions, and, consequently, the quality of patient care.[11,12]

Another significant emotional stressor for clinicians is malpractice litigation. One well-known study estimated that by the age of 65, 99% of physicians in high-risk specialties (neurosurgery, thoracic–cardiovascular surgery, general surgery, orthopedic surgery, and plastic surgery) and 75% of physicians in low-risk specialties (dermatology, family general practice, pediatrics, and psychiatry) had faced a malpractice claim.[13] The impact of malpractice litigation on physicians' personal and professional lives has been well researched, with the research showing consequences that include emotional trauma, job strain, shame or doubt, difficulty coping, increased likelihood of stopping practice, practicing defensive medicine, and leaving a chosen specialty.[14–18]

Given all of these factors, it is therefore imperative that we devote resources to programs that support physician well-being and resilience. Doing so after adverse and other emotionally stressful events, such as the death of a colleague or caring for victims of a mass trauma, is crucial as we are often at our most vulnerable during such times.

Peer Support Program at Brigham and Women's Hospital

Peer support program development

The Center for Professionalism and Peer Support (CPPS) at Brigham and Women's Hospital (BWH) was founded in 2008. One of us (J.S.), as the CPPS's founding director, worked with colleagues to develop the CPPS's mission: to encourage a culture that values and promotes mutual respect, trust, and teamwork at BWH. This mission is enacted through multiple programmatic initiatives, one of which is a peer support program for clinicians. Below we describe the origin, structure, and basic workings of the peer support program.

A foundational component of the BWH peer support program is our commitment to having trained clinician peers (peer supporters) offer support to their colleagues (peers); in our experience, clinicians rarely access available support from mental health providers after adverse and other emotionally stressful events. The initial concept for a peer support program at

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Acad Med. 2016;91:1200–1204.
First published online June 28, 2016
doi: 10.1097/ACM.0000000000001297

BWH was developed in 2004 by Rick van Pelt, MD, and Janet Barnes, RN, JD, in collaboration with multiple colleagues, and was based on a group peer support model. In this group model, clinicians were trained as peer supporters by first responders, a professional group with robust peer support programs.

Our experience with this model, however, was that physicians who participated in the group peer support typically assumed the role of "team leader" and were uncomfortable sharing their emotional distress in front of a multidisciplinary group. This reluctance to expose personal vulnerability is consistent with our understanding that physicians generally find it highly challenging and countercultural to publicly acknowledge their self-perceived weakness in front of nonphysicians. We validated this observation in our 2012 survey study, in which we found that physicians want support from their physician colleagues.[19] Helmreich and Davies[20] aptly state about physicians and pilots that both groups' professions stress "the need for perfection and a deep perception of personal invulnerability." This professional attitude is both necessary and helpful in taking on the risks and responsibilities inherent in providing medical care, yet it can carry with it a propensity for isolation and emotional exhaustion.

In addition, there are situations where a particular clinician has been at the "sharp end of an error," and such a circumstance is not conducive to group peer support. Finally, many of the peer supporters trained in the group peer support model were not comfortable with group facilitation.

Given these shortcomings of the group peer support model, we redesigned the peer support program at BWH in 2009 (following the creation of the CPPS). Our new program provides one-on-one peer support to individuals following emotionally stressful events, including adverse events, from peer supporters who have been there themselves. If a team is likely to be affected, we offer group peer support facilitated by one of two licensed independent clinical social workers—both from our Employee Assistance Program (EAP)—and the CPPS director. Our program was one of the first of its kind, and over 25 national and international programs have been modeled off of it.

In addition to the peer support program, the CPPS also provides defendant peer support outreach to colleagues facing litigation or who have been reported to a regulatory body such as the Board of Registration in Medicine. Our defendant support program works in much the same way as our peer support program, with the defendant peer supporters being clinicians who have themselves been a defendant in a lawsuit.

Peer support outreach

During the first year of our program, after recruiting and training a core group of peer supporters (see below) and publicizing our work to the clinical staff, we sat back and waited for distressed clinicians to request our services. Our phones did not ring. We quickly came to understand that the same forces that keep physicians from speaking up in group peer support sessions were likely keeping them from proactively seeking help. It was clear that we needed to reach out to clinicians in need; we could not expect them to come to us.

Peer support referrals

We work closely with our colleagues throughout the hospital who are well positioned to make peer support referrals, including colleagues in risk management, patient safety and quality, the EAP, and clinical leaders. We also publicize our program through conferences such as departmental grand rounds, so that our colleagues will know they can contact the CPPS director when they are aware of clinicians who have been involved in an adverse or other emotionally stressful event. Peer support referrals are sent directly to the CPPS director who matches each clinician to a suitable peer supporter (see below). The peer supporter then directly reaches out to the peer. Instead of waiting to see who is suffering, we reach out to all clinicians about whom we are made aware. The outreach is confidential and invitational; the peer decides whether or not they want to access the support that is being offered. Depending on the type of event, we may also offer group peer support.

When offering support to a peer, it is important to keep in mind that denial can be a healthy coping mechanism for many people. No one should be made to talk about an event, and some clinicians will choose not to. When a peer supporter reaches out to a colleague who does not want to talk, the supporter expresses understanding and lets them know that peer support is available should they desire it at any time in the future. In addition, whether or not the peer elects to have peer support, the supporter asks permission to e-mail the peer information regarding coping strategies and further resources.

Matching peer supporter to peer

Although there is no algorithm for matching a peer to a peer supporter, there are several considerations we use. When there is an interventional injury, we assign a peer supporter who is an interventionalist because it is a unique circumstance for the clinician to be involved in such an event. With noninterventional events, we sometimes assign a supporter from a similar specialty, while other times we think speaking with a colleague from another discipline may help a clinician feel less judged or stigmatized. We avoid matching junior faculty peer supporters to peers who are more senior. We also work to match microculture and personality style; for example, a vulnerable resident or junior attending might be best served by receiving support from someone whose style is highly empathic. It is also important that the peer supporter not be someone who, in other contexts, is responsible for evaluating the clinician's performance with regard to the event (e.g., a supervisor, safety and quality officer, or the chief medical officer). When a clinician who works in safety and quality provides peer support, they need to make clear that they are functioning as a peer supporter, not as a safety and quality specialist. In addition, anyone who is potentially responsible for investigating the event at issue should not take on a role as peer supporter for that event. Peer support may be offered to anyone identified as having been involved in the event—physicians, nurses, technicians, administrators, etc.

The peer support conversation

We have identified several important components of the peer support conversation: outreach call, invitation/opening, listening, reflecting, reframing, sense-making, coping, closing, and resources/referrals (Table 1).

To initiate the conversation, the peer supporter sends a brief e-mail to the peer

Table 1

Important Components of the Peer Support Conversation

Component of peer support conversation	Sample language
Before the peer has agreed to the support conversation	
Outreach call (normalize the outreach and explain the program)	"We reach out to any clinician involved in an adverse or other emotionally stressful event, only because it can often be really stressful.… Every clinician I know has been in this position at some point in their career, and I have too.… We've found that most of us appreciate talking to a peer because it's hard for other people to know how this feels."
Once the peer has agreed to the support conversation	
Invitation/opening (provide an opportunity for the peer to talk openly about the event)	"Can you tell me about what happened?"
Listening	"How are you doing?"
Reflecting (honor, validate, and normalize the peer's emotions)	"These events can be really traumatic. As you know, as with most traumatic events, the difficult feelings usually slowly lessen over time.… The fact that you are upset shows that you are a caring, committed physician.… Everyone reacts differently to these events, so I am in no way saying that I know exactly what you are going through. But we do know that most of us have some common reactions."
Reframing (put the event in perspective)	"I'm going to tell you some things that you already know on an intellectual level, because sometimes it's important to hear them from a peer: Humans make errors at predictable rates; it's our job as an institution to create systems that prevent errors from reaching the patient.… You are not a bad physician; you have done so much good for people. You are not your error."
Sense-making (encourage the peer to use the event to make positive quality and safety changes, both personal and systems)	"If you can work with your program on looking at systems issues and also teach people about what you've learned, then you can help prevent your colleagues from making a similar error in the future, which is bound to happen if these issues aren't addressed."
Coping (elicit the peer's personal coping strategies, discuss his or her support system, and stress the importance of self-care and mindfulness)	"It's so important to do what you can to take care of yourself at stressful times like this.… What have you done in the past that has helped you through difficult times?"
Closing	"I really appreciate your willingness to share your thoughts with me.… Remember how much good you have done.… This happened because you are human, not because you are a bad clinician."
Resources/referrals (offer to all peers at the end of the conversation)	"As I mentioned, you will likely slowly start to feel better. But if you find that this gets under your skin in some way that is impairing your coping, please let us know.… We don't want you to suffer. You are not alone.… If you have any questions or concerns, let me know, and I'll make sure you get help from whomever you need."

stating simply that they are reaching out as a peer supporter and asking the peer to call or page them when they have a moment. No additional information is included in this e-mail. The outreach call, which is generally scheduled via e-mail, provides an opportunity for the peer supporter to establish context, normalize the outreach, and signal to the peer that peer support outreach is routine. If the peer accepts the invitation for support, the peer and the supporter agree on a mutually convenient time for a conversation, whether in person or by phone. The peer support conversation has various components beginning with the peer supporter inviting the peer to talk openly about their feelings. The peer supporter's role at this stage is to engage in reflective listening. The peer supporter will actively reflect with the peer, honoring the emotions that have been identified with validation and a sense of normalcy while also helping to reframe the event, putting it into a broader perspective. Often this reframing involves helping the peer make sense of the event, reminding them of the important work they do, and, if appropriate, reminding them of the possibility of looking at personal and systems learning to prevent colleagues from making similar errors in the future. A discussion of coping strategies is also important; this involves the peer supporter eliciting the peer's personal coping strategies, discussing their available support systems, and stressing the importance of self-care and mindfulness.

Before completing the conversation, the peer supporter will discuss available resources. These should be offered to all peers, even those who seem to be coping well. The peer is provided with contact information for other organizational resources such as mental health, risk management, and EAP professionals. It is important that the peer knows that the institution does not want anyone to feel isolated or alone.

The peer support conversation is usually a one-time intervention with a phone or e-mail follow-up approximately one week later. The peer is encouraged to contact the peer supporter if there are any ongoing issues; in such cases the peer supporter will facilitate a referral to an appropriate resource such as our peer support psychiatrist or an EAP professional.

During the conversation, peer supporters are careful to avoid getting drawn into judging the facts or details of the case. Many of us as clinicians are accustomed to playing this kind of role with colleagues—consulting and giving advice—but the peer support conversation is not a root cause analysis or legal discussion. In addition to empathic listening, the peer supporter may share their own experience. How much personal information to share will likely vary depending on the situation; as a rule the peer supporter should share enough to express true

empathy and normalize the peer's feelings, but not so much that the focus of the conversation shifts away from the peer. It is also important to understand that while the peer supporter may want to "fix" the peer's emotional pain, this is, of course, not possible. In our experience the value of empathic listening cannot be overstated.

Confidentiality

Peers have a high need for confidentiality; as such, we set a high bar for breaking confidentiality: A peer supporter may break confidentiality if they are concerned that the peer may harm others or themself. In these cases the peer supporter does have a duty to report these concerns to an authority (e.g., the hospital chief medical officer or a mental health practitioner) to help connect the peer with resources acutely.

Another concern with regard to confidentiality is discoverability in case of future litigation. In Massachusetts, peer support interventions are not peer-review protected. Therefore, we do not keep written notes of our conversations. Our risk management department and our medical liability insurers are highly supportive of the program; they feel there is an extremely low risk of any legal harm to the peer, and they feel there is potentially a major benefit in having emotionally supported clinicians who can take better care of their patients.

Recruiting and training peer supporters

In identifying a group of clinicians to serve as peer supporters, we selected physicians and nurses from multiple clinical divisions within the hospital. We felt it was important to have peer-nominated supporters because the peer supporter needs to be both a respected clinician as well as someone with the relational skills to successfully navigate an emotionally charged conversation with a peer. Although we did initially train some residents to be peer supporters, they have mostly graduated and no longer work at BWH.

Before each peer support training session we coordinate with division chiefs and ask them to send out a nomination letter on our behalf. The letter introduces the peer support program and asks clinicians to nominate peers within their discipline who they feel would be well suited to the role of peer supporter. This nomination process helps us identify the most respected and qualified peer support candidates. In collaboration with our EAP colleagues, we have trained a network of over 60 physicians and nurses to provide one-on-one peer support interventions as peer supporters. This training takes place in groups of approximately 15 to 20 participants. The CPPS director also trains peer supporters at outside institutions in interactive half-day workshops.

The peer supporter training includes various exercises that prompt reflection on the significant stresses faced by clinicians after adverse and other emotionally stressful events as well as the serious negative impact those stresses can have on their patients and families as well as the clinicians' lives. The training details both the principles of peer support as well as the common pitfalls in supporting peers. A key component of the training is simulation, where peer support is practiced as well as demonstrated. Finally, when the training is at an outside institution, there is a discussion of how that institution can operationalize the peer support program.

Program support

Our institution supported the creation and development of the CPPS beginning in 2008.[21] This support allowed us to bring several programs, including the peer support program, under a single umbrella. The rationale for the need to support such programs was multifactorial, including such benefits as improved patient safety and quality as well as employee well-being, morale, retention, and productivity. The CPPS staff includes a physician director (0.7 full-time equivalent [FTE]), a physician associate director (0.1 FTE), and a full-time program manager (1.0 FTE). The CPPS director reports to the hospital's chief medical officer, who has consistently been supportive of our work and whose budget provides our financial support.

Program scope

Between January 2012 and December 2015, we have made 220 outreach calls to individual clinicians (between 4 and 5 per month on average). Perhaps not surprisingly, 135 (61%) of these clinicians work in one of four hospital departments: emergency medicine, obstetrics, surgery, or anesthesia. This is likely because the adverse events in these departments tend to be more widely noticed. Over this same period, we have supported over 240 clinicians in multidisciplinary group peer support sessions. We believe the program does not yet reach many clinicians who might benefit from the outreach, such as those involved in an error in the ambulatory setting, where the teams are smaller and the errors less acute. We are working closely with leaders in ambulatory patient safety and other departments we do not currently reach to address this. The work of the CPPS is now also integrated with the Department of Quality and Safety and the hospital's ongoing Just Culture initiative.

Peer Support: Some Limitations and a Way Forward

Our peer support program has some limitations. For example, we recognize that inevitably adverse or other emotionally stressful events occur that may not rise to the level of institutional awareness; as a result, some clinicians in need of support are likely not receiving it. Furthermore, our program does not address chronic stress as effectively as stress from acute events.

The program has face validity; we certainly know the real negative consequences of not providing support to clinicians after adverse and other emotionally stressful events.[22] And as mentioned above, we know from research that physicians want support from physician colleagues.[19] We were also involved in a recently published study showing that speaking with a colleague about the experience was correlated with resilience and positive coping after adverse and other emotionally stressful events.[23] It will be important to study various outcomes of our program so we can continue to improve it. Therefore, we are currently in the process of developing a survey study to ascertain the effects of peer support interventions on the peers themselves.

It is crucial that our health care institutions invest in efforts that acknowledge and address clinician vulnerability. We cannot take care of patients if we ourselves are emotionally compromised and unsupported. Support programs are especially important for academic health care institutions where our students

and trainees are early in the process of professional identity formation. Creating a peer support program is one way forward, away from a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety.

Acknowledgments: The authors would like to acknowledge the important support contributions of Stanley Ashley, MD, chief medical officer at the Brigham and Women's Hospital; Allison Lilly, LICSW; Henrietta Menco, LICSW; and Harpreet Sood, MD, MPH.

Funding/Support: This work was funded through salary support from Brigham and Women's Hospital.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

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