# Peer Support

*"It is a journey into a place of shame, fear, and isolation. Like the underworld of Aeneas, however, this landscape of fallibility contains the spirit of wisdom that can guide the rebuilding of a more humble, humane, and enlightened profession." −John F. Christensen* [1]

Physicians may encounter various stressors in their careers. Certainly one of the most demoralizing is personal involvement in an adverse event that harmed a patient.[2] A key pillar of the Center for Professionalism and Peer Support (CPPS) is the Peer Support Program involving 1:1 support for individual clinicians and group peer support for healthcare teams. To our knowledge, in most peer support programs non-physicians support physicians and other clinicians. In our experience, physicians rarely access available support from non-physicians. There are multiple reasons for this, including the need for confidentiality, concern about reputation, and access issues. A survey study we performed validated this experience.[3,4]

Preceding the creation of the CPPS, the BWH Clinician Peer Support Service was founded by Dr. Rick van Pelt and Janet Barnes, RN, JD, to support BWH care providers following adverse medical events.[5] As a first wave, clinicians across the BWH community were trained to serve as a network of peer supporters as well as co-facilitators of group peer support sessions led by highly trained individuals from our Employee Assistance Program (EAP). When something goes wrong anywhere in the hospital – in the operating room, on the ward, or any place where multiple healthcare team members may feel affected – the group peer support members, led by an EAP provider, are available to facilitate a group peer support for the team. However, physicians who participate in group peer support typically assume the role of "team leader," a role in which they support their colleagues yet refrain from sharing their emotional distress in front of the group. Admitting vulnerability publically is highly challenging and countercultural for physicians; as Robert Helmreich aptly states, our profession "…stresses the need for perfection and a deep perception of personal invulnerability…"[6]

For these reasons, the CPPS developed a 1:1 peer support outreach program for individual physicians and occasionally nurses. In close collaboration with several talented EAP providers we trained a network of over 60 physicians and nurses as peer supporters. When a clinician's colleague, the BWH Risk Management team or EAP leaders inform the CPPS director of a stressful event, a representative from the peer support team reaches out directly to the involved clinician. For example, one of the supporters might page the clinician and simply state: "I am calling as a peer supporter. I heard things didn't go well yesterday, and I'm calling to find out how you are doing. Would it be helpful to talk about your experience?" This helps normalize any emotional distress the physician may be experiencing and also allows the physician to feel supported, talk openly about his or her feelings, and move on to next steps.

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For patients impacted by adverse events, we have multiple resources, including Patient Family Relations, Social Service, and Chaplaincy.

In the past several years, we have supported hundreds of clinicians after significant emotionally stressful events. We continue to look for ways to improve our outreach and efficacy so that we can help prevent burnout, depression, attrition and other adverse consequences that we are all vulnerable to in our profession.

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[1] Christensen JF, Levinson W, Dunn PM. The heart of darkness, the impact of perceived mistakes on physicians. Journal of General Internal Medicine, Vol 7, #4, 424-431, DOI July/Aug 1992: 10.1007/BF02599161 http://www.springerlink.com/content/l47668v1825u2873/

[2] Waterman AD, Garbutt J, Hazel E, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. Jt Comm J Qual Patient Saf. 2007 Aug; 33(8):467-76.

[3] Hu Y, Fix M, Hevelone N, Lipsitz S, Greenberg C, Weissman, J, Shapiro J. Physicians' needs in coping with emotional stressors: The case for peer support. Arch Surg 2011; 312:E1-E6.

[4] Fix ML, Weissman JS, Park E, Hevelone N, Shapiro J. Attitudes and barriers to physicians receiving assistance for personal and professional struggles: A survey of emergency physicians, anesthesiologists, and surgeons. Ann Emerg Med 2007; 50-542.

[5] Van Pelt F. Peer Support: Healthcare professionals supporting each other after adverse medical events. Quality and Safety in Healthcare 2008; 17: 249-252. http://qshc.bmj.com/content/17/4/249.abstract

[6] Helmreich R, Davies J. Culture, threat and error: lessons from aviation. Canadian Journal of Anesthesia 2004; 51:6.

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## Peer Support FAQs

**1) What was the genesis of the peer support program?**

The BWH peer support initiative developed out of our observation that clinical staff were suffering following adverse events. We learned that even clinicians with robust personal support networks stood to benefit tremendously from sharing their experiences with peers who had been in a similar situation and could truly understand and empathize with the pain, stress, vulnerability and fear that are common emotional responses to adverse events.

**2) For what type of events or issues do we provide peer support?**

Peer support is intended for any significant emotional stressor, such as involvement in an adverse event or the death of a young patient or colleague. The Center for Professionalism and Peer Support (CPPS) also has a defendant support program designed specifically to assist clinicians named as defendants in a medical malpractice lawsuit.

**3) What is the goal of peer support?**

Peer support offers a safe way for clinicians impacted by events to talk about their experience and emotions with someone who has empathy from having "been there." While we are not "fixing" a clinician's problems we offer both support as well as strategies that have helped other clinicians in similar situations.

**4) What are the intended outcomes of peer support?**

We strive for three primary outcomes: to help the impacted clinician with emotional healing and wellness, to facilitate early reporting of adverse events, and to enable and promote compassionate and transparent disclosure and apology.

**5) How do staff learn about the program?**

We promote the CPPS through presentations at departmental grand rounds, as well as resident and faculty orientation programs. In addition, all MDs at BWH are required to complete our professionalism training program where they learn about our peer support service.

**6) How does the program work? How do cases come to our awareness, what is the process for intervention?**

A clinician's colleague, the BWH Risk Management team or Employee Assistance Program (EAP) leaders inform the CPPS director of a stressful event. The CPPS director contacts an appropriate member of the peer support team who reaches out directly to the involved clinician.

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7) **How are the peer supporters trained? What is required of them and where do they go for support?**

We ask departments to nominate colleagues who they would want to go to for support. Peer support nominees then make the commitment to attend our half-day training session and then be available to support colleagues as needed. We run quarterly "support the supporters" meetings that provide an opportunity for support, review, and debriefing. The CPPS director is available at any time to advise the peer supporters.

8) **What do we do if the clinician's problems seem more than we can handle or if we believe the clinician poses a danger or risk to anyone involved?**

If the peer is experiencing significant symptoms such as sleeplessness, we encourage the peer to contact – and we provide connections to – specific mental health practitioners such psychiatry or Employee Assistance.

While we are strongly committed to confidentiality, we have to break that confidentiality if the clinician is at risk of harming himself or others. In addition, we have a duty to report if we have direct reason to believe that someone is at risk for unsafe behavior.

9) **How are conversations kept confidential in the event of a law suit?**

In MA peer support interventions are not peer-review protected which means that any documentation is discoverable. Therefore, we do not keep written notes of our conversations. Our risk management department and our medical malpractice insurers are highly supportive of the peer support process.

10) **How long do we work with the clinician? Can more than one peer be involved in a case? Is there follow up?**

The process consists primarily of the initial contact/conversation with an open offer for the clinician to call back any time if it would be helpful. If there are ongoing concerns, we refer to professional resources. We encourage the peer supporter to give a follow up call.

11) **Do we attempt to "match" the peer by specialty, age or gender?**

We have found that some specialties (e.g., interventionalists) benefit from same-specialty peer support. It is often helpful for clinicians to feel that the peer supporter has "been there" and understands the stakes. In other instances, speaking with a colleague from another discipline helps a clinician feel less judged or stigmatized. These decisions are made on a case-by-case basis.

We avoid having a junior faculty member provide peer support to someone more senior; and it is also important that the peer supporter not be someone who, in other contexts, is responsible for evaluating the clinician's performance (e.g., a supervisor, a Quality officer or the Chief Medical Officer). If a clinician who works in Quality provides peer support, they need to make clear which hat they are wearing as a peer supporter.

12) **How do we evaluate the program?**

We have not pursued the collection of outcomes data because we feel that asking clinicians to provide feedback on our intervention – which is also asking them to reflect back over the event in question – has the potential to cause more harm than good. We want the peer support process to function entirely for the benefit of the clinician.

13) **What is the structure of the Center?**

The peer supporters are all volunteers. The CPPS staff includes a physician director (.7 FTE), a physician associate director, a full time program manager, and a full time administrative assistant.

CPPS reports to the Chief Medical Officer who has been consistently supportive of our work and whose budget provides the bulk of our financial support.

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