The Peers in Peer Support:

Challenges of supporting fellow doctors in crisis

Claire Hutton (PhD student -Dept of General Practice, School of Primary and Allied Health, Faculty of Medicine, Nursing and Health Sciences, Monash University

Dr Chris Barton, Professor Grant Russell (Department of General Practice)

Dr Penny Round (Faculty of Education, Monash University)

BACKGROUND:

1. The formalised use of peers within one's own profession represents an important form of support.

Underlying psychosocial processes[1] include:

- **Experiential knowledge** (specialised knowledge and perspectives that people obtain from living through the experience)
- **Social learning theory** (peers, because of their shared experiences, are more credible role models)

2. A number of barriers to seeking help in the medical profession have been identified[2,] including:

- stigma
- embarrassment
- possible impact on career development
- time
- confidentiality including fear of notification

Some of these barriers result in doctors being less likely to seek help from colleagues[3], where they are not able to retain anonymity

[1] Salzer (2002)
[2] Elliott, Tan & Norris (2010)
[3] Hassan (2009); White (2006)

AMA (Vic) Peer Support Service (PSS)

- Introduced in 2008, a phone service for doctors and medical students experiencing difficulties in relation to either work or personal issues
- Set up for Vic and Tas, but all calls from doctors (or those concerned about a doctor) are responded to.
- **Callers (and volunteers) remain anonymous**
- **Volunteers are mostly still working full-time or semi-retired, and carry an AMA phone with them**
- Calls taken 8am—10pm 7 days a week.
- Training and supervision provided
- 36 doctors in total have volunteered (15 female, 21 male), from a wide range of medical specialities.
- Around 800 calls received 2008-2018

Specific research question for this study:

What are the experiences and challenges for doctors providing help to fellow doctors via an anonymous peer support service?

For clarity, 'volunteer' refers to the doctor taking the call, 'caller' refers the doctor calling the peer support service

METHOD

The PSS Call Record completed by the volunteer for every call includes:

- Sections on call time/length, gender, age (*est.*), reason(s) for calling, description of call and help provided, including referrals (*See conference poster for data on calls taken)*

- An optional section at the end asks volunteers:
  - **If they had any difficulties dealing with the call**
  - **If they require any further assistance or information to deal with issues raised by this call**

Volunteer Comments:

Any difficulties in dealing with this call (e.g. lack of info. as to suitable referral agency; identification of potential suicide, self-harm or risk of harm to others)? If so, give details:

Difficulties terminating the call which was "circular" in nature in regards to the family issues

Do you feel you require any further assistance or information to deal with issues raised by this call? If so, give details:

Yes. – How to better deal with a circuitous conversation

Any other comments in relation to this call or the service generally:

If you require debriefing after a call please contact Claire Hutton on weekdays between 8.30am and 5.30pm on 0419 578 060.

Would you like to have this call record reviewed and for feedback to be provided by a supervisor?

☐ YES ☐ NO

If YES, the supervisor will contact you by telephone to discuss the call.

Supervisor's Review:

☐ Checked – no further action required

☐ Checked – volunteer follow-up required (give details)

METHOD *(cont.)*

- All volunteers past and present were contacted. Opt-out consent.
- Researcher-participant existing relationship: I have been involved with PSS since it began, trained all volunteers.
- My professional background is counselling psychology, so see the work through a different lens

- Comments from all Call Records tabulated:
  - Of the 777 valid calls, 436 contained text in this section. All were included.

- Using NVivo 12, inductive coding (no pre-existing framework)
- Peer/supervisor used to 'validate' sample, to check coding is logical and transparent.

FINDINGS: What did the volunteers comment on in this (optional) section?

Wide range of comments

Categories:

- Comments around broader medical system,
- Use of the Peer Support Service (i.e. what kinds of calls volunteers saw as ‘appropriate’)
- Seeking more information (about issues raised by the caller)
- The outcome in terms of whether the caller seemed satisfied or not, and whether the peer was happy or not, with how the call went
- Descriptions of the caller (e.g. their emotional or cognitive state, perceived degree of resilience)
- Volunteer’s emotional response to the call (*e.g. frustration, powerlessness, sympathy, worry*)
- How they handled the call, what they would like to have done differently
- Anonymity

FINDINGS:
What kinds of calls do volunteers find less demanding?

Typical comments:

- *Whilst emotionally draining, it was easy because the caller was reasonable and had a specific request*
- *This was probably a 'good' type of call – a straightforward request, a sober caller, brief, recommendation accepted*

FINDINGS:

Themes in Difficult Calls

Included comments written by volunteer in response to the Call Record question:

Any difficulties dealing with this call?

e.g. answering with a yes

And/or inclusion of words in their response such as:

Difficult, frustrating, hard, challenging, complex, concerned

Illustrative quotes from volunteers:

Caller not open to advice

- Caller blocks every useful avenue
- Most suggestions I made were resisted or refuted

Caller's emotional state

- *The main difficulty was calming down an agitated and almost hysterical young woman who was sharing information very erratically and at a very fast rate*
- *An extremely difficult call, caller was obviously depressed and due to circumstances has numerous barriers to getting help. Initially I felt hopeless myself*

Caller difficult to engage

- *Very difficult to keep conversation going, long pauses*
- *Lass was a poor communicator, answering questions with one or two words, and not wishing to engage.*

No easy answers

- *Had difficulty concluding call, due to lack of constructive steps to be taken*
- *Difficult situation – no clear way of dealing with it that caller hadn't already thought of.*

Powerlessness

- *Identification of potential suicide stressful! Uncertainty if client will do the things we talked about. Feeling responsible for client but powerless.*

Concern about caller's welfare

- *I am concerned that she has no dependent kids to stay alive for. Has not chased up referees or put in job application for next year*
- *Difficult to understand story due to accent and rushed speech. Caller hung up when he realised I could not provide quick fix. I am concerned about the well-being of this caller.*

Interestingly, the volunteers sometimes went on to say that, despite their challenges, the caller still seemed to feel the call had been helpful

Caller difficult to engage

Very difficult to keep conversation going, long pauses. ***She said she felt good about her call. I did not.***

Caller's emotional state

- *An extremely difficult call, caller was obviously depressed and due to circumstances has numerous barriers to getting help. Initially I felt hopeless myself.* ***However by the end of the call, decided the most useful thing was to have provided help, which I think I did***

No easy answers

- *Difficult situation – no clear way of dealing with it that caller hadn't already thought of.* ***At least she acknowledged our discussion had clarified the issue***
- *Had difficulty concluding call, due to lack of constructive steps to be taken.* ***But he appeared to feel the call was worthwhile in having a sympathetic ear to listen to his problems***

DISCUSSION: What do the volunteers find challenging?

The emerging data suggest:

- Risk-related calls are an area most volunteers felt under-confident and inexperienced
- Some challenges can be seen as directly relating to the change in role, the difference between doctor and peer support role
  - Hard to not give advice, but then also hard when you do and the caller doesn't listen
  - Difficulty engaging often seemed a surprise to the volunteer
  - Not having enough information, not being able to directly intervene
  - Underestimating the value of just listening, and helping caller to talk about the problem

All three aspects relate to the theories of peer support:

- The volunteers' 'experiential knowledge' isn't always received well, and they often feel they don't have enough of it
- social learning theory suggests engagement will be straightforward – the volunteer may underestimate what this should look like, especially when callers are in crisis

Conclusions / Limitations

- Volunteers generally finding the experience very rewarding, but also struggle with specific aspects, some of which seem to relate to:
  - the significant differences between the doctor and the peer support role
  - The volunteer's expectations of the peer relationship
- Implications for recruitment and training

Limitations

- Using pre-existing data
  - These questions were answered in different ways by the volunteers. And, no opportunity to adapt the questions through the experience of collecting and analysing the data.
- The voices we aren't hearing are those volunteers who rarely (if ever) wrote in this section.
- Researcher is a psychologist, different professional 'culture', what impact does this have?