Peer counsellors' views on the collegial support scheme for doctors

BACKGROUND The health condition and health-related behaviour of doctors are important to the doctors themselves as well as for their treatment of patients. The collegial support scheme is a county-based and easily accessible health and care service for doctors. We therefore wanted to describe the framework and functions of this scheme and examine its utility.

MATERIAL AND METHOD Fourteen focus-group interviews with a total of 61 peer counsellors from all the counties were conducted. The interviews were recorded, transcribed and analysed with the aid of systematic text condensation.

RESULTS The framework – easy accessibility, a readily available offer of up to three sessions, a high degree of confidentiality and informal contact – was emphasised as crucial for doctors to make use of the scheme. The peer counsellors described their role as that of a listener and supportive helper. They helped bring clarity and discuss possible needs for further follow-up or treatment of numerous different and frequently complex issues. The peer counsellors highlighted three benefits in particular: the scheme helps *raise awareness* by legitimising help-seeking behaviour among doctors, it is a *contingency* scheme, and it *eases the burden* by lowering the threshold to seeking out further advice and treatment.

INTERPRETATION A systematic evaluation of the collegial support scheme is important for an understanding of the totality of the collegial health and care services. The collegial support scheme may lower the threshold to seeking help, and encourage some doctors to seek necessary treatment.

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MAIN MESSAGE

The framework of the collegial support scheme for doctors, its easy and ready accessibility and with a high degree of confidentiality, were emphasised by the peer counsellors as an important reason why the scheme is being used.

The peer counsellors understood their role as primarily that of a listener and as a helper in bringing clarity to varying and often complex issues.

The scheme was described as an awareness-raising and contingency scheme, and as easing the burden by helping lower the threshold to seeking out further advice and treatment.

The health condition and health-related behaviour of doctors are important preconditions for optimal treatment of patients, as well as of importance to the doctors themselves (1–3). Doctors are less absent due to illness than other professions, and seek treatment more rarely (3, 4). Based on this, many countries have developed health and care services specifically for doctors (5–7).

Like all other inhabitants in Norway, doctors have a statutory right to necessary health care (8). Patient safety is regulated by the Health Personnel Act and the Norwegian Board of Health Supervision (9).

In addition, the profession itself assumes responsibility. Doctors shall help, advise and guide their colleagues, as well as provide assistance in case of illness or substance abuse. Doctors shall also look after their own health. These issues are described in Section 2, paragraph 2–3, of the Ethical Code for Doctors (10).

In view of concerns for the health of doctors and their behaviour in case of illness, the Norwegian Medical Association gave support to the establishment of three types of health and care services for doctors in the 1990s. The doctor-for-doctor scheme, in which selected general practitioners and some specialists have their colleagues as patients (11), still exists in half of all counties. In addition, two further schemes were developed: the collegial support scheme (12) and the Villa Sana resource centre (13, 14).

Peer counsellors are found in all counties. These are experienced doctors who have been appointed to help other colleagues in need of support (12). In the recruitment process, emphasis is placed on individual characteristics, gender distribution, the distribution of hospital and non-hospital doctors and their location within the county. The contact is meant to be of a collegial nature – the peer counsellor shall provide advice and guidance (12). The service includes up to three sessions with a peer counsellor, who may receive compensation for this work from the healthcare and pension scheme for doctors (SOP). The peer counsellor keeps no medical records and issues no medical certificates (12). The scheme is free of charge and open to all medical students and doctors in Norway. It is announced on the website and in the *Journal of the Norwegian Medical Association*, as well as in a number of local membership magazines.

So far, the collegial support scheme has not been evaluated, beyond a simple annual registration of the number of sessions and a rough classification of the reasons for contact. Each year, the collegial support scheme is contacted by approximately 100 doctors, hospital and non-hospital doctors in approximately equal measure (15). We wished to

Table 1 Description of the focus-group interview participants

		Number (N = 61)
Gender	Woman	30
	Man	31
Specialty	General practice/occupational medicine	35
	Psychiatry	17
	Somatic hospital doctor	9
Number of years in the medical profession	0–9	0
	10–19	5
	≥ 20	56
Number of years as a peer counsellor	0–3	11
	4–9	20
	≥ 10	30

undertake a more comprehensive, research-based qualitative evaluation and asked the following research questions:

- What type of framework is important for a collegial support scheme, and what functions can the scheme fulfil, as viewed by the peer counsellors?
- In the peer counsellors' opinion, what is the utility of the scheme?

Material and method

Participants

All of the 84 peer counsellors were invited to participate, and 61 of them accepted. All 19 counties were represented. Altogether 13 group interviews and one telephone interview were conducted in the period from August 2011 to June 2012.

The focus groups included 2–8 peer counsellors from the same county, in some cases from two or three neighbouring counties, with interviews lasting approximately 90 minutes. The sessions were mainly held locally, but a couple of group interviews were conducted in the context of the annual meeting of the peer counsellors in Oslo in January 2012. Telephone interview was chosen for one county where assembling a group was impractical. The informants are described in Table 1.

Interviews and analyses

Following a discussion on various methods for evaluation of the collegial support scheme at the annual meeting of the peer counsellors in January 2011, they agreed to participate in a qualitative evaluation that involved focus-group interviews. This method is suitable for studying experiences, attitudes and views, and therefore useful for applying an exploratory perspective on issues that have been little studied previously (16). The interviews were led by a moderator (KR) and an assistant (OGA), both of whom are doctors with experience from evaluations of other support schemes for doctors.

The participants were asked to describe the framework of the collegial support scheme, the functions that the scheme fulfils, the type of requests received, the role of the peer counsellor and how they assessed the utility of the scheme. The statements in the audio files could not be linked to individual participants, and the participants had the opportunity to undertake a «quotation check».

The interviews were recorded onto audio files, transcribed and analysed with the aid of systematic text condensation inspired by Giorgio, as described and modified by Malterud (17). After the entire material had been read to establish an overview, two interviews were read in detail and coded in accordance with the general topics in the interview guide by the authors separately, before being discussed until an agreement was reached. After the coding of the remaining interviews, topics were identified across the entire data set.

Ethics

The participants have given written informed consent to participation in the study, which was not subject to notification to the regional ethics committee.

Results

Framework of the scheme

The peer counsellors described how the scheme's framework is important for doctors to make use of this service. They emphasised that this ought to be a readily available and easily accessible, informal low-threshold option. When doctors make contact, they tend to have delayed this decision for a long time and need help quickly. Since the counselling session is not documented or entered into any medical records, the doctors are confident that the information remains confidential. Some doctors had reported to their peer counsellors that asking for help from someone not previously known to them, who has no relationship to others in their working environment, is a key factor. Especially when the doctor's own network is insufficient, help from a peer counsellor may be crucial.

The confidence that the peer counsellor would understand their situation (because he or she is also a doctor) was an important factor, especially if workplace issues were involved.

> *And then it's a great help to have someone who's in the same situation, who perhaps may have a better understanding of the situation you're in. And that applies especially to cases where ... I sometimes see cases where you are caught for providing the wrong treatment or accused of having done a poor job in some way or other, or done something you shouldn't have done at work, where it could be really difficult to discuss this with an outsider* (group 3).

The function of the peer counsellors

The peer counsellors noted how doctors keep their troubles to themselves for a long time. The issues may be complex and «huge questions that people grapple with» (group 2) once they seek help.

They claimed that over time, a shift had occurred in the reasons for making contact, from more individually related and private problems to more workplace-related issues. This could involve conflicts and unrest, often associated with reorganisation processes, reactions to adverse events or excessive workloads. Considerations regarding change of specialty or of leaving the medical profession were also topics that were raised.

In some of the focus groups, the peer counsellors reported that they were contacted by a growing number of young women, sometimes as early as during internship or at the end of their studies. They described feelings of being overwhelmed by the responsibility they were expected to assume, they are high performers and have frequent feelings of self-reproach.

The peer counsellors also more frequently met doctors from other cultures:

> *In particular, I have our foreign colleagues in mind, they are really afraid of not living*

up to the expectations from their permanent, seasoned Norwegian colleagues. They often come to Norway alone, meaning that they have no small children. And expectations are that there are no limits when it comes to workload, for example. Excessive demands become a recurring pattern. At the same time, not being Norwegian is in itself a hindrance to entry, at least to smaller groups of colleagues – professional communities (group 5).

Individual reasons for making contact could include substance abuse, illness – their own or a family member's – or troubled family relationships.

An important element of the peer counsellor's role was to listen. The sessions would often be the first opportunity to think aloud together with someone else, an aid to sorting through, categorising and structuring the problems, and to discuss alternative options and ways to address the issues.

We should be advisers and coaches, but I believe that the most essential quality we need to have is to be able to just listen (group 8).

Many peer counsellors stated that part of their role consisted in normalising reactions and emotions in the person seeking help. They may need to remind this person of the fact that other doctors also make mistakes, and to ask him or her what they «would have said to their own patients» in a similar situation. In the case of formal complaints, the sessions often focused on helping relieve the doctor of the sense of chaos and paralysis.

The peer counsellors would also help assess the need for further follow-up or treatment. Many of those who came to sessions were advised to consult their GP, a psychotherapist/family therapist or another specialist.

Since the reasons for seeking help were so complex, the peer counsellors reported that they could be expected to assume/fulfil many different roles – ranging from that of a therapist to spokesperson or attorney. Some doctors who sought out the scheme might therefore feel that their needs were not entirely met. Some peer counsellors discussed the possible usefulness of merging the collegial support scheme with the doctor-for-doctor scheme. Some of the peer counsellors had also occasionally chosen to switch role from that of a peer counsellor to that of a doctor.

Utility of the scheme

Awareness-raising and preventive. Peer counselling was described as contributing to establish a culture that acknowledges the emotions and needs of doctors. This legitimises help-seeking behaviour among doctors.

... the goal should be to make ourselves superfluous, by creating a new culture that permits even doctors to have emotions and needs (group 12).

Over time, the peer counsellors developed a keen eye for colleagues who are in need of help, and it had become legitimate for them to ask whether something was wrong and provide support to doctors in various contexts. Thus, the collegial support scheme could become a model for how doctors can interact and help each other.

Many of the peer counsellors referred to the similarities between their role and that of a supervisor, noting how it was natural for them to encourage formalised supervision. The supervision arena was described as important for capturing the need for different forms of collegial support.

Contingency. The peer counsellors described their work as an important contingency scheme that ought to be available, similar to the municipal crisis management teams. The scheme is a safety net for those who have failed, committed an error or are struggling in other respects.

But I believe that it's very important that we have – so to speak – that people know that the scheme exists, because it's an anchor and a support. That is, that there is a scheme available if things should go wrong (group 3).

The awareness of having a collegial support scheme was described as «having a Valium in the desk drawer» (group 6). Doctors may think: if things get worse, I know that there is someone with whom I can discuss this. This may help them feel less vulnerable in their situation.

The importance of spreading awareness of the scheme to others in the doctors' environment was also referred to. People who have met doctors embroiled in a difficult situation have occasionally alerted a peer counsellor. Such alerts have come from parties including therapists or colleagues, next of kin, lawyers in the Norwegian Medical Association, supervisors of foundation doctors, or the Norwegian Labour and Welfare Administration.

Some of the peer counsellors also reported to have initiated contact themselves, occasionally because of an alert (as described above), because a colleague featured in the media, because a colleague had been reported to the supervisory authorities or because they observed that a colleague was troubled by something. This contact was often welcomed, but they also reported that the contact had been perceived as unwanted. This could be for reasons of cultural differences or be seen as offensive if substance abuse was involved.

The peer counsellors discussed whether the scheme succeeds in reaching out to those who need it most. Should more doctors get in touch? Is the scheme perceived as too formal, are people unaware of it, is it seen as shameful to make contact, or perhaps the idea does not occur to someone who is in the middle of a crisis? One of the groups discussed whether doctors perhaps have sufficient networks outside the peer counselling scheme.

Easing the burden – lowers the threshold to treatment, inspires confidence. The peer counsellors reported that doctors who had made use of the scheme tended to be satisfied and grateful after the session(s). They found the sessions meaningful and useful, and saw them as necessary to be able to move on. Many felt relief. Those who had seen a peer counsellor had often recommended others to see one. The contact with a peer counsellor could be the first step towards seeking regular treatment. The scheme was described as an important supplement to the GPs and the doctor-for-doctor scheme.

The peer counsellors communicated that they would have preferred to establish contact with some of the doctors *before* the problems had assumed unmanageable proportions and some boundaries had already been crossed, for example in the case of a revoked licence or a report to the police. Many pointed out that doctors often seek help very late – they do so only when standing on the edge of the abyss.

Discussion

The peer counsellors noted that the framework of the scheme, such as confidentiality, readily available appointments and a meeting with someone who understands, but stands apart from the job situation, is important for doctors to make contact. This accords with international studies that have found that doctors more easily make contact with schemes that provide similar frameworks (7, 13, 18). The peer counsellors nevertheless ask themselves whether perhaps even more doctors ought to make use of the scheme.

Some of the peer counsellors have noticed that it has now become somewhat more common for doctors to support each other. This may imply a decrease in the need for the collegial support scheme. A survey conducted ten years ago revealed that 40 % of the doctors were unaware of the scheme; this was especially true among younger doctors as well as those in the northern counties (19). This may indicate that the scheme ought to be promoted more actively.

The function of the peer counsellors must be adapted to a broad range of complex and

serious issues. Colleagues who face conflict-ridden or difficult working conditions often need a personal contact, which the peer counsellor can provide. However, in light of the reports of an increasing number of contacts related to (excessive) workloads and pressure in the workplace, it should be considered whether the function of peer counsellors may also help maintain system failures that otherwise would be useful to address through other channels, such as the management or the elected employee representatives.

The increasing number of young women doctors who attended the sessions may indicate that the function of the peer counsellors could change somewhat. We know that the proportion of women doctors is increasing, in Norway as well as internationally. It is thus important to be aware of possible needs for other types of help and support resulting from this change.

The peer counsellors identified three kinds of utility provided by the scheme: that it helps raise awareness, that it constitutes an important contingency scheme and that it eases the burden, thus lowering the threshold to treatment and inspiring confidence in the helper. The peer counsellors claimed that the scheme has contributed to a change in the doctors' attitudes towards seeking help for themselves as well as helping their colleagues.

Could there be a contradiction between use of the collegial support scheme and upholding professional solidarity? Many doctors with some years of experience perceive a loss of personal autonomy and status, and may have their hands full taking care of themselves in the daily grind. This could provide less room for positive collegial relationships, and the peer counsellors must step in. This may perhaps represent an increasing challenge to the peer counsellors – on the one hand being able to provide support to colleagues who feel that the health services provide less room for individual autonomy, while on the other hand communicating that increasingly, professional autonomy must be of a collective nature, and that doctors must be there for each other (20). When professional loyalties are under threat, it is especially crucial to take care of each other as colleagues, for example through a scheme for provision of collegial support.

Most of the peer counsellors emphasised that the scheme is important in terms of the contingency it provides. It could be an essential safety net in a job situation in which the risk of exclusion (for example by committing a mistake or falling ill) can be perceived as threatening to an extent that may even cause some to plan suicide, as described by one of the support colleagues. Data from Norway as well as the UK confirm that doctors who seek help tend to report suicidal thoughts more often than other doctors (7, 13). The importance of the safety net may simply consist in the opportunity it provides to make contact with a support colleague, since this may be sufficient to help someone withstand a difficult situation.

Moreover, it is important that the contact with the scheme can be established through others, such as next of kin or a colleague, when the doctor feels powerless to do so. Norwegian doctors are still reluctant to take their own needs into account when it comes to treatment and sickness absence (3).

The peer counsellors reported that in their feedback, the doctors who came for help noted that the contact eases the burden and lowers the threshold to seeking further advice and support. When helping to categorise and identify needs, the peer counsellors may point out and insist on the seriousness of the situation, while the doctor perhaps may initially play down or reject any needs for treatment. The contact in itself helps build confidence in the benefits of seeking help.

A higher frequency of treatment, especially psychotherapy, has also been documented after use of another low-threshold service for Norwegian doctors, the Villa Sana resource centre, as well as internationally after use of similar low-threshold options for doctors (7, 12, 13, 21). Support schemes for doctors appear to result in more appropriate use of public health services.

Strengths and weaknesses

The strength of qualitative studies, such as focus-group interviews, is their ability to provide experience-based knowledge, rather than a quantitative ranking of importance or the proportional distribution of opinions (16, Ch. 1). On the other hand, this may limit the generalisability of their results to a wider group. In this study, however, we have included doctors from all of Norway's counties, thus making for transfer value to the group of Norwegian peer counsellors as a whole. The issues may also be transferable to similar support schemes in Denmark and Sweden.

The fact that both of the interviewers were doctors themselves, with special familiarity with support activities, may constitute a methodological weakness. On the one hand, this may have facilitated their understanding and recognition of the descriptions provided, but on the other hand it entails a risk of making assumptions about phenomena that thereby remain underexplored. The different types of prior understanding between the interviewers, whereby KR has a background in individually oriented clinical studies and OGA in long-standing research on the group of medical practitioners as a whole, may have helped provide nuance to the interpretation of various phenomena.

In this study we have investigated the assessments made by the peer counsellors and their reporting of what the help-seekers have told them. The framework, function and benefits of the scheme should also be described by the doctors who have used it before a total assessment of how it functions and ought to function can be made. Such a study is currently being planned.

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