International Journal of Health Services Research and Policy
www.dergipark.org.tr/ijhsrp
IJHSRP
e-ISSN: 2602-3482

Research Article

PHYSICIAN HEALTH AND WELLNESS – ASSESSMENT OF A PEER SUPPORT PROGRAM IN A WESTERN CANADIAN TERTIARY HOSPITAL PEDIATRIC DEPARTMENT

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Abstract: *Peer support programs (PSP) have been used and found to be effective in mitigating burnout by utilizing the innate tendency to respond and empathize with shared difficulty. Such a program was established in the Pediatrics department of a tertiary care hospital in the Western Canadian city of Regina in January 2021. This study evaluates the effectiveness of the peer support program and its value in managing stress among physicians. Between January and March 2021, 14 Physicians were paired to have informal virtual meetings every two weeks for three months. A mixed-methods design was used to assess the program. Once peer support sessions concluded, physicians participated in a cross-sectional survey and were interviewed to assess their experiences and perceptions of the program. Descriptive statistics were computed from survey data. Interview data were analyzed qualitatively and coded for themes based on recurring issues. Workload, lack of support, administrative work, and high-intensity cases were mentioned as some stressors by the physicians contributing to burnout. Survey findings (response rate 64%) showed that 78% of participants perceived the workplace as stressful and chose a paired over group peer support, 56% found the program helped to alleviate stress and burnout and all respondents preferred support from co-physicians compared to other health care professionals, Physicians recommend the continuation, expansion, and advocacy for the program while providing a more formal structure with administrative support for schedule integration and protected time.*

Keywords*: Peer Support, Burnout, Physician Peer Support, Physician Mental Health*

Received: January 24, 2023 *Accepted: November 22, 2023*

1. Introduction

Burnout is a term that is often used within the medical community, referring to feelings of depletion and emotional exhaustion. It is unsurprising that this term is common as one in three physicians experience burnout [1]. The importance of addressing burnout is highlighted in the maladaptive coping outcomes that distressed physicians face: withdrawal, substance abuse, depersonalization, cynicism, and suicide [3, 4]. Secondary outcomes include riskier prescribing, less empathy, and increased medical errors [2, 3]. Meaning, that as the physician suffers, so too does the patient. Burnout has also been attributed to an increased cost to the healthcare system from physician turnover and early retirement [5]. The cost of burnout among Canadian physicians is estimated to be $213.1 million [5].

Under normal circumstances, physicians suffer from higher levels of stress and burnout than the general population [6]. The stress and declining mental health continued to rise [8] due to the devastating impacts COVID-19 has had from March 2020 to May 2023 [7]. Healthcare professionals involved in

the care of COVID-19 patients had significantly higher negative mental health outcomes including depression and anxiety [9]. Given the devastating outcomes that occur when physicians experience burnout, prevention is important to explore, both in and outside of the pandemic [5].

The American Medical Association articulates six strategies to reduce physician burnout and improve well-being namely, investing in research, creating positive work environments, reducing administrative burdens, creating positive learning environments, enabling technology solutions, and providing support to clinicians and learners [10]. Most of the burnout management and prevention actions require organizational, system, and institutional involvement [11], therefore relevant policy development and process implementation must be in place. Such actions would take significant time and effort, at times requiring extensive review and approval processes from relevant authorities, whereas, through the Peer Support Programs (PSP) physicians can help each other. According to the British Columbia First Responder's Mental Health Committee in Canada, "*co-workers who have had similar experiences can provide support and referral assistance through peer support, improving the lives of their peers and helping them towards recovery, empowerment, and hope*" [12]. Thus, by implementing a pilot PSP, it would become possible to identify and address physician wellness needs [8]. Examples of PSP in healthcare settings in North America include Indiana, USA [13]; Ontario, Canada [14]. The purpose of this study is to explore how, and to what degree, Peer Support (PS) works, the benefits it offers, and the specific aspects that may require further development and improvement in the Western Canadian context.

2. Materials and Methods

The study method included two stages: The establishment of PSP at a tertiary care hospital and PSP evaluation through interviews, surveys, and data analysis.

2.1. PSP Establishment

Step 1: In January 2021, a PSP was established in the Pediatrics Department of Regina General Hospital (RGH) located in Regina, Saskatchewan, Canada. Physicians (staff and residents) from the department were recruited to participate in the PSP based on self-interest. Participants (n = 14) ranked potential partners and were paired by common ranking and similarity in practices. Table 1 provides an overview of the participant characteristics.

Table 1. Participant Characteristics

Participant Category	Participant Number	Specialty	Experience
Staff Physicians	N = 10	Pediatrician, Neonatologist	1 to 15 years
Resident Physicians	N = 4	Pediatrics	Years 1 and 2

Step 2: Participants were asked to meet with their partners every two weeks for three months. 6 meetings per pair were held as part of peer support. Each pair was provided with a guideline of potential topics (e.g., any negative feelings in the weeks, overall work duties, dealing with unpleasant experiences, accomplishments, and work objectives until next meeting) to discuss but encouraged to welcome all other conversations. Given the COVID-19 pandemic restrictions, meetings were held virtually from January to March of 2021, and the number of meetings was decided by the pairs. Physician support resources were shared with the participants.

2.2. PSP Evaluation

Following the PSP program, a mixed-method study design was employed to evaluate how the PSP was perceived and its value in helping with stress management. Both qualitative and quantitative data were collected through interviews and surveys for evaluation of the program.

Step 1: All physicians were invited to participate in virtual one-on-one interviews (n = 8) between July to November 2021. Eligibility criteria were based on the physicians who were partnered and participated in the program. There were no restrictions to interview participation based on the number of times the partners successfully met. Interview questions were developed to fulfill the study's specific objectives, and to understand participants' experience in, and perception of, Peer Support. Questions also addressed ideas related to Physician wellness, stress, and burnout. All interviews were audio recorded and transcribed verbatim.

Step 2: Following the virtual one-on-one interviews, a cross-sectional survey consisting of open and closed-ended questions was employed to evaluate the overall experience and feedback of participating physicians (n = 9). Specific questions about whether they would prefer group or paired peer support and recommend the program to other colleagues were asked.

Step 3: Interview data were analyzed using NVivo 12 qualitative software. Data were analyzed qualitatively following the Braun & Clarke (2006) linear, six-phased thematic analysis method [15]. Inductive codes were developed and grouped into themes. Subthemes were assigned while reviewing, defining, and naming the themes. Once member checking was completed, interview transcripts were returned to the participants to check for accuracy. Two researchers analyzed the interview data simultaneously. Survey data were analyzed statistically using IBM SPSS Statistics 22 software to compute descriptive statistics.

Ethics approval was obtained from the Research Ethics Board, Saskatchewan Health Authority. (Approval date: October 07, 2020; SHA File # REB-20-88)

3. Interview Findings

The interview findings are presented in four categories, as presented in Table 2, and described in detail below.

Table 2. Summary of Interview Findings

Categories	Themes	Subthemes
Factors related to physician burnout	Personal factors	Work-life balance
		Expectations
	Organizational factors	Administrative work
		Lack of resources and support system
		Workload
		Compartmentalization
	Patient population factors	High intense cases
		Psychological energy
		Second victim
Barriers related to the PSP	Organizational barriers	Work Schedule
		Department size and physician availability
		Geographical locations
	Social barriers	Covid-19 pandemic
		Stigma
		Working connection
	Personal barriers	Commitment and willingness to seek help

Table 2. Continued

Categories	Themes	Subthemes
Perceived benefits from the PSP	Psychological benefits	Breaking stigma
		Stress release and sharing burden
		Normalization
	Building relationships	Commonality and community
		Program implementation and continuation
Strategies for engagement	Structure of the PSP	Formal and protected time
		Pair-oriented and group support
		In-person meetings
	Previous connections and work familiarity	Pre-existing relationships
		Matched sub-specialty

3.1. Factors Related to Burnout and/or Stressors

The factors and stressors related to burnout were described by physicians in three major themes: personal factors, organizational factors, and patient population. The personal factors were focused on meeting family and social needs while working long hours while the organizational factors included administrative burden, lack of resources and support system as well as increased workload due to physicians' shortage and the COVID-19 pandemic. The patient population theme included high-intensity cases (i.e., neonates in ICU), the need for high psychological energy, and adverse outcomes of the high-intensity cases – all of which contribute to the higher stress level.

3.1.1 Personal Factors

a. Work-life balance: A recurring theme that was present in all physician interviews was work-life balance. Work-life balance was described as a major personal stressor that is consistently present and remains a challenge for physicians to maintain personal (family and friends) relationships outside of work. As most physicians were not in group practice, finding time for family or self-care remained difficult as work was often brought home or into time off. There is also an expectation to take care of one's mental health and well-being. Physicians found that in the past this expectation could be met with the ability to have time off. However, with the increased workload physicians have struggled with meaningful time off, which is equivalent to the emotional and psychological energy that is personally expended.

"*I remember the first week I took off, early in the winter…. I think the first three days I was hours on the phone every day"* (SP1)

b. Expectations: The expectations that physicians face in their defined role can act as a major stressor. Given the shortage of pediatricians in the department, staff are faced with working more hours. On top of the increased hours, staff also face expectations of long hours and intense patient cases without the support of the Pediatric Intensive Care Unit (PICU), which is in another city of the province.

"*I think the hours are stressful just in terms of the call we have to do with short pediatricians here. So, some of us do more than in a perfect world we would want to be doing"* (SP2)

3.1.2 Organizational Factors

a. Administrative work: Paperwork is a common stressor associated with administrative responsibilities. Physicians have noticed an increase in the amount of paperwork that has become up to half of their workday. This decreases the amount of time to see patients and continues to add an element of stress. In addition to the paperwork, physicians feel that the amount of clerical work is not recognized

by the administration and lacks appropriate compensation. There has been an urge for a change in contracts to reflect this in practice.

"We have spent a lot of time on, in the last two years trying to rewrite our contract in a way that's a bit more appropriate for our area and how we work" (SP1)

b. Lack of resources and support system: Lack of resources has been expressed in both terms of the number of pediatricians working and the administrative resources available to them. The location of the PICU being in another city leaves high-intensity cases to on-call physicians; resulting in a smaller team (due to physician shortage) with fewer resources to deal with high-burden cases.

"*It's the part that's a lot about resources relationships, structures. Those are the ones that often create more stress in the sense of stress where it's a burden."* (SP2)

The organization of individual practice can be found to be isolated. There is often one physician in the ward at a time compared to other specialties which indicates a lack of collaboration. This carries over into peer support as working alone removes the natural tendency to not only collaborate on cases but debrief stressful and emotionally tolling cases. Likewise, physicians found that there were not many initiatives in place by the department to support them both in their workload and time off but also in their mental health. There was a lack of prioritizing mental health or the time it takes to achieve mental health.

"You know, convince the department that it's worth exploring the concept that people have internal unmet needs" (SP1).

"In Regina, we don't have that proximity. It's more in the sense that if you're in the hospital, usually you're the only one in the hospital and most people work outside. So, you don't get those opportunities to sort of sit down and talk about challenges that are happening with everyone's practice." (SP7)

c. Workload: Since the beginning of the pandemic, physicians have been experiencing many challenges, one of which is an increased workload due to isolated practices and a lack of physicians to support. Physicians have also been challenged to reduce their leave to meet current demands, which encompass interrelationships between the pandemic, physician shortage, and clerical work.

"You know you're not working with other pediatricians in the same setting or other physicians on the same day on the same patient. Compared to the team of nurses, who are all working together on the ward. So, I think it's more of an isolated experience." (SP3)

"So, for me, I'd say timing and scheduling is a big stressor and not having lots of free time. Because often spend longer of hours at the hospital and I need a lot of sleep." (SP4)

d. Compartmentalization: Physicians find that the workload and case burden can often not be left at work. There is a psychological toll that often follows them home, compounded by a physical amount of work that cannot be completed during office hours. Physicians find themselves bringing work home with them or on vacation. The responsibilities that come with the profession mean working outside of clinic hours, whether this be patient consultations, self-directed learning, case studies, or paperwork.

"There are definitely patients that keep you awake at night because you feel like you just know you haven't figured it out yet and you're worried. And I think always have to take that home. So sometimes I wonder if you know I would be happy as a preschool teacher because I feel like I, you know, similar patient population but I would have to take less home in terms of that burden of care I guess that is always there. I am always checking my EMR. I am always checking my email. And there always seems to be patient stuff coming at me even if I'm on holiday" (SP2).

3.1.3 Patient Population

a. High-intensity cases: The pediatric practice has unique stressors attached to the patients that are being taken care of, such as neonates in intensive care units. Where there is a role to not only take care of the patient and their best interest but also the families. The adverse outcome of these high-intensity cases also leaves.

"The babies come with some added psychological flavor to it. A bit more extreme on both sides, the good and the scary parts." (SP1)

b. Psychological energy: With both acutely ill and terminally ill cases, physicians find there are innate emotions and investments within their cases. Often these emotions come home with them and create emotional stress. Especially when cases cannot be diagnosed or end in poor outcomes.

"I think in pediatrics there's a huge stressor getting invested in cases and having things that are emotionally draining. Seeing trauma and seeing sad cases that affect kids can be a huge stressor" (SP5)

c. Second victim: There is an added stressor with adverse outcomes and high-intensity cases that can leave physicians feeling at fault. Leaving physicians feeling uneasy and distressed with high-intensity cases.

"And I think there is a lot of pressure to be perfect and get the right diagnosis and right answer and not always having the ability to do that can be a stressor. And sort of something you carry outside of work with you at the end of the day." (SP3)

3.2. Barriers to Engaging PSP

Barriers to engaging PSP were grouped into three themes: organizational, social, and personal. Busy work schedules, a number of available physicians, and their geographical locations are some organizational barriers mentioned by the physicians in providing and seeking peer support. Certain social factors such as the pandemic, stigma, and lack of prior working relationships contributed to the challenges in engaging in the program. Finally, lack of engagement from one or both parties was mentioned as a barrier that contributed to a sense of "forced wellness". Each theme is described in detail below.

3.2.1 Organizational Barriers

a. Work schedule: Physicians are experiencing an increased workload that includes patient interactions and clerical work. The intent to engage in the PSP was present, however, the ability to balance workload, personal life, and the pandemic left limited time. Almost all physicians expressed the need for protected time supported by the department.

"I think by definition everyone, at least all my pediatrician colleagues, are busy with not just work but their personal lives. I think peer support is extremely important, it's just like my physical exercise, you have to prioritize it and schedule it." (SP8)

b. Department size and physician availability: The size of the department limited the participant pool and the number of available partners. There were 17 physicians and 4 residents working at the hospital during the study period. However, the relatively small size of the department also provided familiarity, which was described as a strength for some.

"I think it's hard in a smaller program because when you know everyone so well, is going to be a lot less formal." (SP3)

c. Geographical locations: Although virtual platforms aided in the ability to connect in different cities, geographical location remained a barrier. Partners who were not consistently in the same location felt the ability to make natural connections was inhibited. This barrier overlaps with the barriers of COVID-19.

"We couldn't even have spontaneous bumping into each other in the hospital or anything like that where we could have like a quick chat. Because we work hardly ever in the same city. So limited in that sense." (SP5).

3.2.2 Social Barriers

a. COVID-19 pandemic: The pandemic offered unique challenges to PSP. Physicians found that the virtual format did not offer the same natural connection as meeting in person. Some physicians emphasized this was compounded by virtual burnout.

"I think the timing was a bit unfortunate. Well, yes and no. I think when this started we all needed a lot of support because it was the middle of COVID but at the same time I think we were a bit burnt out in terms of virtual meetings and virtual connections and we wanted real connections." (SP2)

b. Stigma: Physicians found a hard time balancing the need to be well with the idea of being told to be well, especially within a time frame. In order to efficiently practice wellness, it was felt that stigma needed to be addressed by both participants and the department.

"It's kind of an interesting balance of like if you're getting tired and burnt out and you're not taking time for yourself, that's almost like another job. You come home and your checklist is I have to study, but I also have to go for a run and be well. It sort of all adds up." (SP3)

c. Working connection: Physicians who had a prior working relationship with their colleagues were able to connect faster and understand the needs and expectations of their partners. Familiarity increases the ability to have a positive outcome. Partners who had not had the same prior connection or level of comfort noticed this was a barrier to communicating.

"The two most important things are the connection and the time. Once those are established, they just have to think about it as a living relationship on the go." (SP1)

3.2.3 Personal Barriers

Personal barriers such as commitment and willingness to seek help contributed to the challenges in engaging in the program. Most of the physicians identified their personal need for peer support. However, one physician perceived it as "forced wellness" and the lack of personal investment in both parties was a barrier to sharing their experiences freely. Physicians whose partners were equally invested were able to harbor a deeper connection. And those without the perception of forced wellness were more likely to make time for their partner.

"Once the more sort of global kind of a human feeling and interaction goes, then people have to do a bit of like I said an introspection. As in, is there something that I might need more help with more specifically? I mean nobody can help anybody that doesn't feel like he or she should be helped." (SP1)

3.3. Perceived Benefits from the PSP

The benefits of this PSP were identified into two broad themes – psychological benefits and building relationships. The program helped physicians break the stigma, release stress, share burdens, and normalize. Physicians were able to develop a sense of commonality and community by fostering trust, building connections, and resiliency.

3.3.1 Psychological Benefits

a. Breaking stigma: The ability to talk and relate openly with partners allowed physicians to break down walls and address stigma by reciprocal sharing of their perceptions of health and wellness. This helped to eliminate the stigma around innate resilience.

"Once you have more time spent talking with your peers about the struggles, the barriers, the difficulties, then the more open you are with sharing things with your colleagues and the easier it is to build resiliency skills as a team." (SP5).

b. Stress release and sharing burden: Physicians found that the ability to talk to peers who had similar experiences helped to relieve stress.

"Recognizing that we are human and that our internals have to work in a reasonably balanced way. Sometimes, if we take too much stuff on then we just need to give some to somebody else." (SP1)

c. Normalization: The participants found that internal PSP, versus external, helped normalize the idea of wellness through in-depth conversations with colleagues. Internally the program was perceived as a "scheduled reminder," and integrated wellness into their work environment. These conversations were found to extend beyond the PSP meetings.

"I think that we can provide as much education as possible to physicians in general about wellness, about ways of building resiliency, about trying to normalize wellness, normalize the process of building resiliency as much as possible, and if we can educate a few physicians every year. Then eventually they will educate more physicians and it will be a snowball effect." (SP5).

3.3.2 Building Relationships

a. Commonality and community: Participants found that PSP allowed them to relate and feel understood. They developed a sense of commonality and community between colleagues. Despite the limitations on the number of times met (pair dependent), physicians found PSP to be an outlet for stress. The ability to engage with colleagues was met with support and relation through shared experiences. The ability to have a deeper connection fostered trust and understanding while building resiliency. For these reasons, physicians felt that peer support was valuable in highlighting the importance of physician health and wellness in the department.

"This is something that is certainly good, there is no doubt, that there is enough data to show. That if we acknowledge it or not, that having at least one person where we don't sort of internally limit the sharing and things like that, is a very useful thing." (SP1)

b. Program implementation and continuation: Peer support was well received by physicians. One of the more prevalent outcomes was the hope physicians had for the project to be continued and implemented in their department. Physicians saw the project as advocacy within their department towards mental health and are hopeful that this will ignite changes.

"I like to look forward to that this might be implemented into more departments and might be a staple." (SP3)

Physicians advocated for the importance of wellness, which, as a matter of fact, should be considered as part of medicine. They reiterated the need for protected time and that the administration should do more to ensure this.

"I do think that there still needs to be a culture to say wellness is important, it's part of medicine. It's still unfortunate some people push back against the idea of wellness. And so I think that needs to shift." (SP5)

3.4. Strategies for Engagement

Strategies for engagement in the PSP were described by physicians in two major themes: PSP structure and previous connections. The physicians recommended the PSP to be formal, pair-oriented, and in-person setting. Pre-existing working relationships and familiarity in types of practice are some factors to be considered while developing a PSP.

3.4.1 Structure of the PSP

a. Formal structure and protected time: When asked what participants thought of a formal peer support program, the responses were mixed. Some physicians mentioned a formal training program would be an added barrier due to time restraints. Where a lack of time already presents as one of the primary stressors, physicians are worried that a formal training program may add, rather than reduce, stress. Some participants saw the benefits of formal training to give or receive support to be beneficial but again saw time as a major restraint. However, some participants proposed that formal training may benefit in the long run as it may make communication more effective and efficient in the future.

Although formal training was not seen as necessary, a more formal structure for guidance was suggested by most participants. Formalities such as reminders, set aside time, and strategies for efficient and meaningful engagement were recommended. The idea of a more structured program was brought up by almost all participants with suggestions that the program should include more guidance into expectations and practice.

Each participant found the most limiting factor to participating in peer support to be time restraints. Time restraints included both personal and professional time.

"So, if we had more strategies with maybe like an introductory, introduction to peer support and tips and tricks that would help. As well as having protected time to hold peer support meetings." (SP5).

*"And I think the reality is that there's a ton of things we all know we can do for wellness and sometimes it just comes down to not having the time to do them."(*SP3)

b. Pair-oriented and group support: Individuals found the formatting of support in pairs to be valuable. Participants thought the idea of a group setting could be an adjunct on top of the paired support. Practicing with partners allowed participants to form a relationship that they were comfortable in sharing. However, the perceived downfall to peer support for one participant was that the lack of investment by the partner was a barrier that may not have been present in a group setting.

"I think I would do it more of like group-based. It was nice to get to know one one-on-one, but I think even if you did it group-based, I think each time you would have a different smattering of people that would come. So, you would be able to get to know different people depending on ya, who were able to attend that particular event. So, I think that would be a good addition or tweak. Even if you were paired and then had some group opportunities maybe. "(SP2)

"And who knows, it might evolve into a multi-person instead of pairs. Where people might point out well four is better actually. "(SP1)

c. In-person meetings: Virtual meetings, as a result of COVID-19, aided individuals to meet safely but limited the ability of a natural meeting. Most participants found an in-person meeting would have aided with the depth and frequency of meetings.

3.4.2 Previous Connections and Work Familiarity

a. Pre-existing relationships: Given the short duration of the pilot project, pairs with a pre-existing relationship were able to meet more naturally and engage in deeper conversations more quickly. Given the small size of the department, participants were familiar with their partners, which was found to aid in initial conversations.

"I think we; we are naturally close in uh wavelength and it's been uh a quite pleasant interaction. I think that we both felt that we could easily just talk about things that there wouldn't be that many people to talk with. So, it worked out good, I think." (SP1)

b. Matched sub-specialty: Physicians found their connection to be more natural when their types of practices, and years of experience, matched. For example, pairs who were specialists were able to relate easily with patient characteristics and practice strains.

3.5. Survey Findings

Figure 1 summarizes the survey findings. The total responses were nine out of fourteen participants. Among them, 78% of participants perceive the workplace as 'quite a bit' to 'somewhat' stressful. 100% preferred peer support among physicians compared to support inclusive of other health care professionals. 78% of respondents prefer paired over group support. 56% found the program helped alleviate stress and burnout. Most agreed that they would recommend the PSP to another colleague or a health professional. Some major stressors related to physician's work were long hours, administrative work, lack of resources (including staff or physician shortages), high-pressure situations, and the recent pandemic. The respondents emphasized the benefit of in-person meetings over virtual ones.

4. Discussion

In this study, we examined the utility of a PSP and its use in mitigating burnout. The most cited barrier by physicians was time constraint, which is consistent with PSPs cited in the literature. Physicians report that lack of free time to utilize PSPs was a significant barrier and deterred them from utilizing programs to their full potential [16, 17, 18]. Similarly, studies found that participation rates decreased with a lack of protected time [18,19]. Our participants discussed that protected time would allow further participation. COVID-19 was a unique barrier to PSPs implemented in 2020 onwards. The recent pandemic highlighted the need for peer support, but it also provided barriers. Other preliminary studies of PSP during COVID-19 also found virtual burnout and concerns about engagement sustainability [20].

A common barrier noted in the literature that decreases participation is confidentiality [3, 4, 16, 18]. This was not reported in our study. With larger studies and interdepartmental PSP, physicians feared confidentiality breaches [3]. To mitigate this, institutions have successfully taken a multidisciplinary approach, using legal and risk management teams to support physicians and their confidentiality [18]. This consideration may become important upon expansion of our PSP beyond one department.

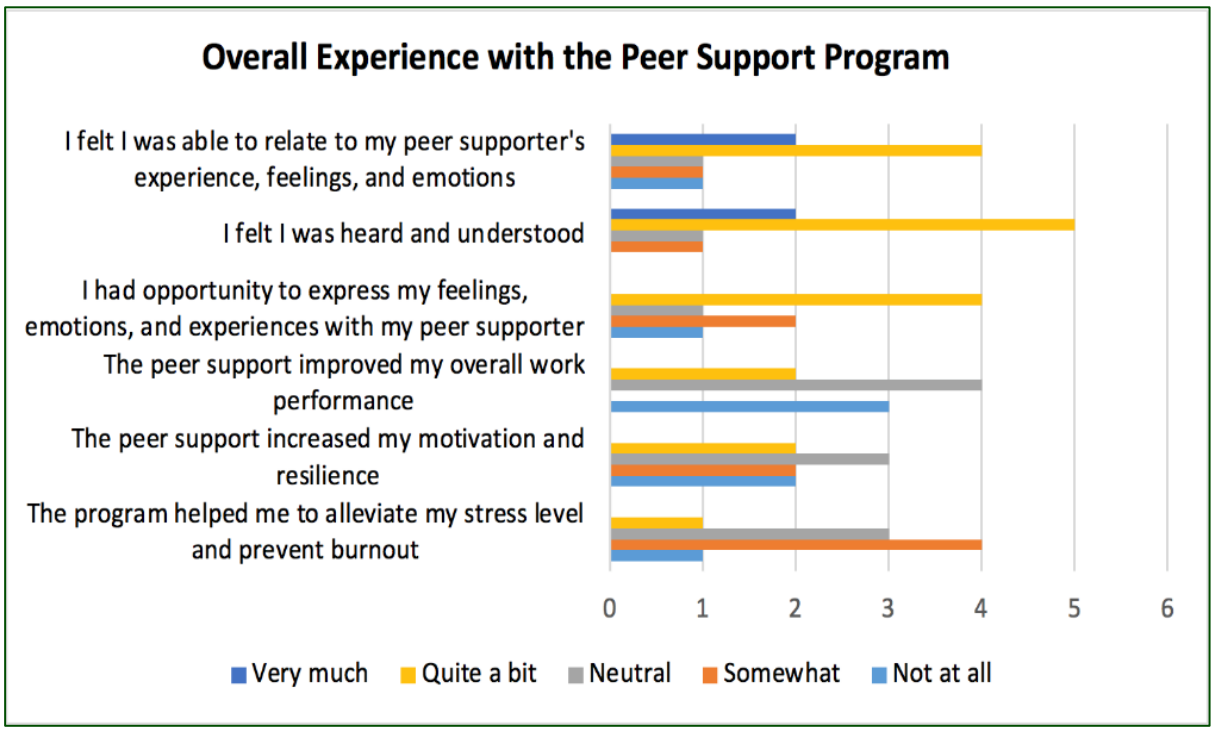

Figure 1. Overall Experience in the Peer Support Program at the Regina General Hospital, Department of Pediatrics. A cross-sectional survey, n = 9.

Within our survey, there was a lack of consensus on the ability of PSP to mitigate burnout. More time in the program may change this outcome as longer-standing PSPs within the literature have reported significant mitigation of burnout as an outcome of peer support [1,4]. The majority of these outcomes were found in "Baliant-like" PSPs, where physicians received support following adverse events [2]. These trends in the literature combined with the positive outcomes of our study may elicit the potential for a hybrid model.

Previous studies in the literature report that physician colleagues were the most popular potential source of support [3]. Similar to our study, the literature shows pre-existing relationships or natural connections increased positive outcomes of PSPs [3]. Studies have found that the ability to relate to

colleagues within the same department increased compared to different departments [2]. Our PSP was able to address the long-standing stigma of physician mental health where the opportunity to engage in the program felt normalized.

Given the short timeline of our study, it is important to consider PSP sustainability. Literature shows volunteer efforts within PSPs may not be sustainable and should be taken into consideration [18,20]. Alternatively, programs that utilize paid positions and paid time have had long-term success [21]. Regardless, PSPs are a low-cost support method, which has contributed to its feasibility and sustainability [4]. Within our study, there was an expressed want for formality around participation expectations, such as meeting times and potential topics. Other studies that used a more formal approach to meeting time, such as a Baliant approach, found there were often missed opportunities and an inability to address chronic stresses at the moment [1]. Regardless of whether there are suggested meeting times, it is evident that peer support must be implemented in a way that does not increase physician workload.

5. Conclusion

The program was well received by the physicians and the intent to move forward with participation was high. The physicians were able to self-reflect on what brought stress in their day-to-day practice, especially when high-intensity cases were involved. Listening to other physicians' stressors allowed for self-reflection through the understanding of commonalities and shared feelings. A structured format to guide the conversations, strategies for efficient and meaningful engagement, pair matching based on types of practice as well as formalities such as reminders, and set time aside were recommended. While 56% of the participants found the program helped alleviate stress and burnout, the majority agreed that they would recommend the PSP to others. In-person meetings (both paired and in group settings) were preferred by almost all physicians – which could potentially be more effective for the program's success. From the regulatory perspective, the authorities can consider implementing department-protected time to increase the ability for physicians to participate. Our study confirmed the feasibility of PSP and a desire for its continuation at RGH's Pediatric department and beyond.

Given the increased prevalence of burnout, especially in light of the recent pandemic, the use of peer support can help aid physicians in preventing adverse outcomes. Peer Support has utility in mental health and burnout intervention. Our study highlights the benefits, barriers, and strategies for other institutions to implement a peer support model and shows similar outcomes to the literature. We believe the results of our study can impact physician well-being by allowing physicians to have a positive community and psychological impact within the program. The implication of physician well-being extends beyond the work environment but to the patient and the system. The role of a physician is to aid in the prevention and recovery of patients, and to do so physicians must have the ability to promote their well-being.

Limitations:

This pilot project was implemented within a small and specific department with a limited number of physicians. Physicians here may experience different work environments and therefore stressors. Our study may experience non-response bias, where the response rate was 57.14% and 64.23% for the interview and survey, respectively.

Ethical statement:

Ethics approval was obtained from the Research Ethics Board, Saskatchewan Health Authority. (Approval date: October 07, 2020; SHA File # REB-20-88)

Acknowledgment:

Research Department, Saskatchewan Health Authority and College of Medicine, University of Saskatchewan. Dr. Abid Lodhi and Dr. Omopelola Sotomi of Regina General Hospital Pediatrics Department for their support in establishing the Peer Support Program.

Conflict of interest:

No conflicts of interest

Authors' Contributions:

All authors read and approved the final manuscript.

The level of their contributions are as follows:

M.V.E: Data collection, Investigation, Formal analysis, Original and final manuscript preparation

P. N: Conceptualization, Methodology, Resources, Investigation

S.N: Research design, Methodology, Investigation, Formal Analysis and Final manuscript preparation

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