Understanding peer support for doctors

Philosophiae Doctor (PhD) Thesis

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“I will attend to my own health, well-being, and abilities in order to provide care of the highest standard.”

The 2017 Revised Declaration of Geneva - A Modern-Day Doctor’s Pledge (1)

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Acknowledgments

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Sammendrag

Våre målsettinger i denne avhandlingen var å undersøke opplevelsene til leger som hadde benyttet seg av støttekollegaordninger i et kort (10 dager) og lengre (1 år) perspektiv. Legers helse og velvære er viktig av flere grunner. Leger rapporterer høye nivåer av utbrenthet, depresjon, manglende god balanse mellom jobb og hjem, og at de går på jobb selv om de er syke. Hvordan leger har det, påvirker både kvalitet på behandling og deres evne til å ivareta pasientene. Legers helse og velvære er derfor viktig av hensyn til den individuelle legen og familien, i tillegg til at det påvirker helsetjenesten.

Anerkjennelse av at legers helse er viktig ble tydeliggjort da Verdens legeforening (World Medical Association) i 2017 reviderte den universelle legeeden, også kjent som Genève-deklarasjonene. De la til «Jeg vil ivareta min egen helse, mitt velvære og mine evner, for å kunne gi omsorg av den høyeste standard» (1). For første gang er legenes egen helse gitt oppmerksomhet i denne eden og legens helse settes i direkte sammenheng med evnen til å kunne yte best mulig pasientbehandling.

Vi har studerte to norske kollegiale tilbud for leger, Villa Sana og Støttekollegaordningen. Ved bruk av semistrukturerte, individuelle dybdeintervjuer ønsket vi å undersøke hvorfor legene søkte kontakt, hva de opplevde som meningsfylt og nyttig ved tilbudene, og om tilbud bidro til å endre handlingsrommet deres i forhold til egne utfordringer. Forskningen satte søkelys på å fange opp legenes refleksjoner og opplevelser. Denne avhandlingen er basert på innhentet informasjon fra leger som hadde valgt å søke hjelp. Tematikken ble studert ved hjelp av 3 forskjellige tilnærminger:

I den første artikkelen undersøkes hvorfor legene søker seg til et kollegatilbud. Legene oppga et bredt spekter av kontaktårsaker. Det var alt fra bekymring og å søke råd, frykt for ikke lenger å mestre hverdagen, til at de var sykemeldt og lette etter en vei tilbake til eller videre i arbeidslivet. De beskrev både jobbrelaterte utfordringer og private utfordringer som kontaktårsak. Deres forventninger til tilbudet varierte fra ønske om samtale og råd, til karriereveiledning, til ønske om behandling. Tilbudets rammer, med konfidensialitet og ingen journalskriving, ble ansett som svært viktig for å senke terskelen for å søke hjelp i kollegiet.

Den andre artikkelen belyser hvilken påvirkning det kan ha å benytte seg av et kollegialt tilbud. Dette gjøres ved å undersøke hvilken betydning legene tillegger opplevelsen ett år senere, og er gjort ved sammenligning av intervjumaterialet med samme gruppe leger i 2018 og i 2019. Resultatene ble belyst av organisasjonskulturteori og teori rundt 'det skjulte pensum' i medisin. Et gjennomgående tema i intervjuene fra 2018 var legenes utfordringer med å akseptere egne vansker på grunn av tanker og holdninger rundt hvordan en lege bør være, nemlig sterk og en som setter pasienten i første rekke. Dette stemte ikke med hvordan de oppfattet sin egen situasjon som leger. Ett år senere, i 2019, hadde de beveget seg mot å tilpasse synet på hva det innebærer å være en lege, til også å kunne romme flere aspekter slik som å kunne være syk, å kunne ha begrensninger og å ha egenverdi utover arbeidsprestasjon. I 2019 fortalte legene at de hadde gjort endringer i både arbeid og privatliv. Noen hadde begynt i terapi eller annen behandling. Studien viser at å benytte seg av et kollegialt tilbud, ser ut å kunne åpne for en videre fortolkning av hva det innebærer å være lege. Dette kan bidra til økt bevisstgjøring av normer i profesjonskulturen som kan vanskeliggjøre selvivaretakelse. Det kan hjelpe legene til å ta bedre vare på seg selv.

Den tredje artikkelen retter søkelyset mot hvordan forskjellige elementer i utformingen av det kollegiale tilbudet påvirker den potensielle nytteverdien for legene. Resultatene er diskutert i lys av organisasjonskulturteori. Legene beskrev at de ønsket et tilbud som skiller seg klart fra en vanlig lege-pasient relasjon. De satte ord på at de ønsket, og fikk, en åpen dialog innenfor en ramme av opplevet psykologisk trygghet. De verdsatte fleksibilitet og uformelle omgivelser. Noen av disse kvalitetene kan tilskrives den formelle strukturen til den kollegiale tjenesten. Andre kvaliteter baserer seg på hvordan støttekollegaene utøver sin rolle. Kollegiale støtteordninger kan legge til rette for refleksjon og avdekke og sette spørsmålstegn ved antagelser og holdninger som tas for gitt i medisinsk kultur, som kan hindre selvivaretakelse. For noen bidrar refleksjonene til at de ser nye muligheter med hensyn til hvordan de skal håndtere sin vanskelige situasjon videre. For det andre kan refleksjonen i tillegg bidra til at de begynner å stille spørsmål ved sin egen rolle som lege og den profesjonskulturen de er en del av.

Kollegiale støtteordninger for leger kan tilby en spesiell mulighet til å revurdere holdninger og verdier knyttet til den medisinske profesjonskulturen som kan vanskeliggjøre selvivaretakelse. Dette kan bidra til å oppdage nye muligheter til hvordan man kan forholde

seg i en vanskelig situasjon. Holdninger knyttet til 'det skjulte pensum' i medisin ble utfordret, slik som tanken om at leger skal arbeide overtid, gå på jobb selv om de er syke og å håndtere både tidspress og emosjonelt press med å arbeide hardere. Ett år etter kontakten med støtteordningene hadde flere av deltagerne i denne studien justert sine holdninger til legerollen mot økt aksept for egen psykisk eller fysisk uhelse. Å akseptere sin situasjon ser ut til å være avgjørende for å komme i gang med nødvendige endringer både på jobb og i privatliv.

Resultatene fra denne avhandlingen underbygger teorien som er brukt. Avhandlingen viser at verdier og holdninger knyttet til 'det skjulte pensum' i medisin kan bidra til dårlig selvivaretakelse. Den viser også at tilbud som oppfattes som en psykologisk trygg arena kan åpne for refleksjon rundt, og bevisstgjøring av, disse holdningene i den medisinske profesjonskulturen.

Avhandlingen er et bidrag inn i diskusjonen om legers helse generelt og kollegiale støttetilbud spesielt. Den peker på viktigheten av å ha hensiktsmessige støtteordninger som kan gi leger et rom for refleksjon som kan bidra til endringer. Den understreker også betydningen av økt bevisstgjøring i legegruppen, på profesjonsnormer som kan hindre selvivaretakelse, og på viktigheten av refleksjon rundt hvordan man skal håndtere dette i arbeidshverdagen.

Thesis summary

The overall objective of this thesis is to study the experiences of doctors who have attended peer support in a short term (10 days) and a long term (one year) perspective. Doctors 'well-being is important for several reasons. They report high levels of burnout, depression, sickness presenteeism, and lack of a healthy work-home balance. Their well-being may influence both quality and capability of patient care. It is therefore important to the individual doctors and their families, as well as the whole functioning of the health care.

The recognition of the importance of doctors 'well-being is illustrated by a new inclusion in the Declaration of Geneva – A Modern-Day Doctor´s Pledge – which was revised by the World Medical Association in 2017. For the first time, the doctor´s own health is given attention in this pledge, and is linked to the doctor´s ability to provide the patient the best care possible: 'I will attend to my own health, well-being, and abilities in order to provide care of the highest standard.'(1)

We have studied two Norwegian peer support services for doctors, Villa Sana and the local peer support service, Støttekollegaordningen. Through in depth, semi-structured interviews with doctors who had attended the services, we sought information about why they reached out to the services, what they experienced as meaningful and beneficial, and what changes they attributed to attending the services. The research attempted to capture their reflections and understanding. The studies solely investigate the reasoning and experiences of the group that chose to seek peer support. The topics were studied through three different approaches.

The first paper addresses the reasons doctors seek peer support. The doctors reported a broad spectrum of reasons for seeking support, spanning from concerns and seeking advice, feeling unable to cope any longer, to having been on sick leave and now looking for a way back to work or a way out. They described both work- and privately-related reasons for seeking support. Expectations of the help they would receive varied from dialogue and advice to career guidance to treatment. The confidential setting and the no record-keeping policy of the service were thought of as being important in lowering the threshold for help-seeking.

The second paper addresses whether the use of peer support influences change processes through investigation of what the doctors attributed to the received support a year later. This was done through comparison of interviews with the same doctors in 2018 and 2019. The results were interpreted in light of theory of organisational culture and the hidden curriculum in medicine. A common theme in the first interviews (2018) was the difficulty of accepting the individual situation because of beliefs and values concerning what a doctor ought to be. A doctor should be strong, healthy, and always put the patient´s needs first. But the private challenges did not match these expectations. A year later (2019), the interviewees seemed to have adjusted their expectations of what it means to be a doctor to also embrace and accept more human aspects, such as illness, limitations, and self-worth beyond work performance. The doctors reported having made changes both in relation to work and in their private relationships. Some had attended therapy and treatment. It thus seems that peer support can facilitate awareness of and promote changes in professional cultural values that help the doctors to self-care.

The third paper addresses how various elements in the peer support services' design impact whether and how the doctors can benefit from it. The results were discussed in light of theories on organisational culture. The doctors wanted peer support to have a different quality from that of a regular doctor/patient interaction. They expressed that they needed and found psychological safety and an open conversation in a flexible and informal setting. Some of these qualities are related to the formal structure of the service, whereas others are based on the way the service is practised. Peer support can enable reflection about, and questioning of, basic assumptions in professional medical culture. For some, the reflections help them to see new opportunities regarding how to handle difficult situations, and may also lead them to question the professional culture that can hinder self-care.

The study shows an increased awareness in the interviewees about the expectations related to the so-called hidden curriculum in medicine, expecting doctors to work more than stipulated hours, sickness presenteeism, and dealing with both time and emotional pressure by working harder. Peer support for doctors seems to offer a unique possibility to re-examine values and beliefs concerning medical culture that can hinder self-care, and thus to broaden the scope of appropriate actions to handle difficult situations. A year after peer support, the participants have reconsidered and adjusted these expectations towards

acceptance of their own mental and physical issues. Such acceptance seems to enable the doctors to initiate changes both at the workplace and in the private situations, helping them to see and attend to their own needs.

The results in this study underpin the theoretical perspectives presented. They demonstrate that values and underlying basic assumptions in the medical culture, as described in the hidden curriculum, seem to hinder self-care. They also show that providing a psychologically safe space can enable discovery of and reflection around basic assumptions in the professional medical culture.

The thesis constitutes a contribution to the discourse on physician health in general, and on the specific issue of collegial support services. It emphasises the importance of having appropriate support mechanisms that can provide doctors with a space for reflection, which in turn can lead to change. Furthermore, the study highlights the significance of raising awareness among the medical community regarding professional norms that may hinder self-care, and the importance of reflecting on how to address this issue in daily work.

Abbreviations

SOP – Sick leave- and retirement compensation fund for doctors

GP - General Practitioner

NHS - National Health Service

PHP - Physician Health Programs

ALS - Amyotrophic Lateral Sclerosis

SK - Støttekollegaordningen/the local peer support service

AMA - The Australian Medical Association

LQI - Longitudinal Qualitative Interview approach

NORDOC - The Longitudinal study of Norwegian Medical Students and Doctors

MBI - Maslach Burnout Inventory

Papers in the thesis

Paper I

Taxt Horne IM, Veggeland F, Bååthe F, Isaksson Rø K

Why do doctors seek peer support? A qualitative interview study.

BMJOpen 2021;11:e048732. (2)

Paper II

Taxt Horne IM, Veggeland F, Bååthe F, Isaksson Rø K

How distressed doctors act and relate to their challenging situation a year after seeking counselling at a centralised peer support service – a qualitative study.

(Submitted BMC Health Services Research January 2023)

Paper III

Taxt Horne IM, Veggeland F, Bååthe F, Drewes C, Isaksson Rø K

Understanding peer support: A qualitative interview study of doctors one year after seeking support

BMC Health Services Research 23, 324 (2023). (3)

Chapter 1 Introduction

Doctors and the need for peer support services

Internationally doctors have, over time, reported high levels of burnout (4-18), which can lead to personal suffering and reduced quality of patient care (8, 19, 20). As doctors go to work while ill and are often reluctant to seek treatment and health services (21-27), peer support services have been instituted, aiming to lower the threshold for doctors to seek help.

Peer support is a general description of a concept initially used in terms of peers as fellow patients. The National Health Service (NHS) defines peer support accordingly: 'Peer support is a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management' (28). In the context of this thesis, peer support is used to describe support from someone with the same professional occupation. This type of support can take the form of advice, mentoring, or simply providing a listening ear. It is different from a doctor-patient relationship. In this manner, occupational peer support can lower the threshold for seeking help by offering a unique source of support that is independent of work, home, or the healthcare environment (29). A meeting between equals. We know peer support services may be the first place doctors turn to when they need help and advice (30, 31). The peer support service can be seen as a preventive intervention.

The definition of prevention varies, depending on the background or tradition, ranging from a disease-preventive perspective to a health-promoting perspective. It involves the implementation of measures that enhance quality of life and the ability to cope. One common classification is the division into three categories of prevention that are appropriate for participants with different levels of risk factors: universal, selective, and indicated (32-35). Universal preventive measures are intended for an entire population or all members of a group, while selective measures are targeted at a subset of the population that is at an increased risk of becoming ill. Indicated measures, on the other hand, are intended for individuals who exhibit a risk factor. Even though it is not easily adopted to the field of occupational distress, in this context, peer support for doctors can be classified as indicated preventive measure (35).

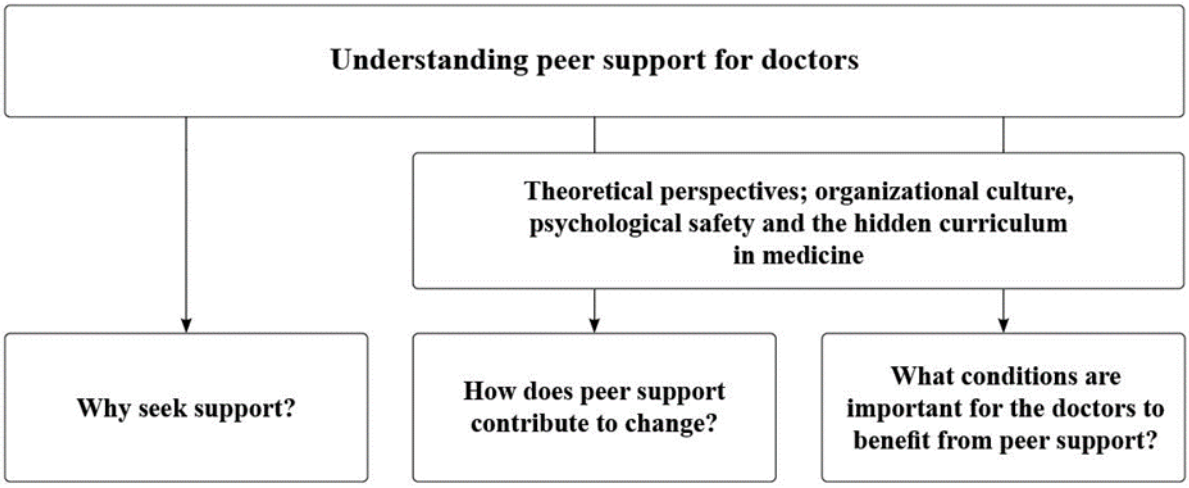
While the drivers of burnout and the prevalence of mental illness among doctors have received attention, and peer support services have been instituted, we know less about why they sought support and what they experienced as the result of these services.

We have some research indicating beneficial effects on mental strain after doctors have received peer support (31, 36-43). However, there is a knowledge gap concerning experiences with occupational peer support in general, and peer support for doctors in particular. Little is known about how doctors experience attending peer support services and how they make use of these experiences.

Also in Norway, doctors who had attended peer support were followed up with surveys (42). They reported an improved situation with less burnout, less mental distress and less job stress at both one and three years after attending peer support. But questions about how these improvements were attained remained. To understand more about how this service, and other peer support services can be utilized by doctors in managing their health and wellbeing was an important background for the present thesis.

This thesis builds on qualitative studies addressing Norwegian doctors' experiences of attending a low-threshold peer support service. It investigates doctors' handling of their own mental health and self-care through attending peer support by exploring two of the three peer support services for doctors in Norway: Villa Sana and Støttekollegaordningen (SK)/or local peer support. Both peer support services are free of charge and offer confidential support, a collegial discussion without treatment or medical record. We set out to investigate why doctors attend peer support, if/how the support offered is perceived as supportive, and how doctors understand any long-lasting impact of peer support. The results were interpreted in light of relevant theoretical perspectives. Figure 1 gives an overview of the three aspects we have studied in order to understand peer support; why doctors seek support, how peer support contributes to change and what conditions doctors describe to be important in order to benefit from peer support. Regarding the two last aspects we have used theoretical perspectives concerning organisational culture, psychological safety and the hidden curriculum to interpret and explain our results.

Figure 1, overview of thesis



When studying preventive measures for doctors, it is useful to define 'doctors wellness' and what we mean by 'unwell'. In this thesis, the definition proposed by Brady et al. in their systematic review on the definitions and measurements of the term is used: 'Doctor wellness (well-being) is defined by quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experienced in connection with activities and environments that allow doctors to develop their full potentials across personal and work-life domains' (44).

'Unwell' is understood to be the lack of one or more of the above-mentioned dimensions of wellness, but may also include the presence of illness and symptoms of psychiatric diagnosis, such as anxiety, depression, PTSD, and burnout. This heterogenicity of 'unwell doctors' thus ranges from wanting to discuss something with a peer to being diagnosed with a mental illness. It is not the intention of this thesis to diagnose, evaluate, or discuss psychopathology and treatment. However, to understand and respect the explicit need to offer exclusive, preventive services to doctors, it is necessary to outline what we need to prevent and what this looks like among doctors today.

Accordingly, I here give a brief background on medical professionalism, that can be important in shaping doctors' understanding of role identities and the culture at work, including self-care. The relationship between doctor health and patient health is introduced, the most reported mental distresses doctors struggle with are presented, as well as help-seeking behaviour among doctors, interventions for doctors and the possible relationships between peer support and improved well-being.

To discuss doctors' help-seeking behaviour, it is useful to know something about medical professionalism, as this shapes doctors' understanding of role identities and the culture at work.

Medical professionalism

'The linkage between job and career satisfaction and life satisfaction is especially important for physicians, because their professional role has traditionally been so central to their self-concept' (45)

As a regulated profession, doctors hold, through legislation, a protected position in the labour market (46). Historically, doctors have been able to operate relatively freely within the occupation, but with guarantees of professional and ethical quality in their work through the established professional contract with society. This contract is based on broad public trust and grants social status, professional autonomy, and authority to doctors (46). Medical professionalism is a wide term commonly thought to include a set of values and behaviours such as integrity, following a code of practice and professional guidelines, compassion, altruism, striving for improvement, and partnership with other healthcare co-workers (47, 48). Professionalism can also be demarcated by examples of unacceptable or unprofessional (mis)conduct, such as engaging in personal relationships with patients, or working while under the influence of alcohol or drugs. There are also less explicit norms of conduct referred to as 'the hidden curriculum' in medicine. 'The hidden curriculum' consists of what is taught outside of the formal curriculum in medical school and in the medical professional culture (49-52). It can manifest as values, attitudes, beliefs, and related behaviours, such as to prioritise technical skills and scientific knowledge over empathy and communication, or achievement and competition over teamwork (51, 53). The display of personal emotions is often regarded as unprofessional. The negative aspects of these unspoken 'rules' may contribute to sickness presenteeism and shame by advocating values such as always putting work first and a reluctance to adapt to the role of a patient (51-55). 'The hidden curriculum' is therefore relevant when studying preventive measures and peer support, and is a dimension of professionalism that will be further discussed in Chapter 3.

It is acknowledged that a lack of professionalism in the workplace, or unclear expectations of acceptable conduct, can lead to medical errors, adverse events, and hazardous working conditions (56). These conditions can affect doctor health, and doctor health may in turn influence patient health. Let's consider the doctor-patient relationship in terms of influences on health behaviour.

Relationship between doctor health and patient health

There are several studies discussing a relationship between doctor health and patient health. According to Frank et al., doctors who have healthy personal habits are more likely to discuss related preventive behaviours with their patients in a variety of areas such as exercise, seat belt use, smoking, hormone therapy, nutrition, alcohol consumption, screening for breast cancer, and influenza vaccination (57). In a systematic review from 2015 by Scheepers et al. they found a relationship between doctors' occupational well-being and the quality of patient care (20). The occupational well-being of the doctor was found to positively contribute to patient satisfaction, patient adherence to treatment and the overall quality of care (20). A literature review by Angerer et al. looking into doctors' psychosocial work conditions and quality of care found that a good working environment is related to both better patient-reported and doctor-reported treatment quality (19). Better working conditions for the doctors were linked to both better treatment results and fewer complications. A poor working environment was associated with an increased number of reported errors and complaints.

At the other end of the spectrum, some studies find that unwell doctors are more likely to order unnecessary care and commit medical errors, and their patients are more likely to suffer from an increased risk of mortality and longer post-discharge recovery times (9, 10, 44). Unwell doctors are also more likely to leave practice (45). Leaving practice can have negative consequences on patients' health. A Norwegian study from 2022 found a close correlation between length of regular general practitioner–patient relationship and patients health: Length of relationship is significantly associated with fewer acute hospital admissions and lower mortality (58).

In an article from 2015, Konrad et al. discuss doctors´ occupational well-being: 'Workflow (time pressure and a chaotic work pace), job characteristics (lack of work control), and poor organisational culture (e.g., lack of values alignment between staff and leadership) were

strongly associated with adverse doctor reactions' (45). Konrad argues that adverse doctor reactions such as dissatisfaction, stress, burnout, and intention to leave practice are associated with adverse health care quality and errors. However, Konrad also points to inconsistent findings in the association between reported unwell doctors and poorer patient care: There is a discrepancy between self-reported errors and systematically reported errors, where self-reported errors tend to yield higher numbers (10, 45). One suggested explanation is that doctors act as buffers at work, limiting the consequences of adverse work conditions in patient care, despite being strongly affected. 'The implications of this for doctor health, mental health and well-being are worth contemplating' (45).

A lack of wellness, a challenging work situation, and mental health issues are common drivers in doctors' seeking peer support (30, 59). By offering a venue to strengthen professional identity, enhance health and life quality, and to prevent burnout, peer support services may thus also indirectly influence quality of patient care (35). We need more knowledge about why doctors attend peer support, and their experiences of the support given. It is important and relevant to identify conditions that enable doctors to benefit from these services, as doctors' health affects the quality of health services.

Two clarifications are in order when discussing psychopathology in an occupation as measured by psychometric tests: It is important to note that these investigations usually do not include doctors on sick leave or other absenteeism, which also might be due to psychopathology. This is called '*the healthy worker effect'* (60) and is a systematic bias in occupational research resulting from the study of a non-clinical population. Second, it is also important to consider that the results of quantitative studies are intended for research purposes and do not include clinical assessments, thus the prevalence claims should not be thought of as prevalence of clinical diagnosis (61). However, for the purposes of this thesis, the research on psychopathology in the medical profession exposes the need for preventive services.

Doctors mental distress and burnout

'Today, burnout is the single most prevalent psychological complaint in the caring profession. So prevalent is it that, at some point in our career, anyone working close to human suffering will develop some aspects of it'. Gerada, 2020 (62)

Burnout is a self-reported job-related syndrome and is defined in ICD-11 as follows: 'Burnout is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) a sense of ineffectiveness and lack of accomplishment. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life' (63).

As burnout is one of the illnesses resulting from prolonged exposure to stress, it is abundantly discussed in research literature pertaining to doctors' health (5-8, 10-18, 27, 43, 64-81). Internationally, a high incidence of burnout among health care professionals and doctors specifically has been reported since the 1980s. In research literature from the US, burnout is characterised as a national epidemic that affects half to two-thirds of practicing doctors (14, 16, 79).

In research literature, burnout is predominantly defined as measured by the Maslach Burnout Inventory (MBI). A systematic review of the prevalence of burnout among doctors by Rotenstein et al. (76) found that, in 185 world-wide studies from 45 countries, 86% of the studies had used a version of the MBI as measure. In MBI, the burnout syndrome is defined by the presence of *emotional exhaustion* (presence of energy depletion or exhaustion), *depersonalisation* (the presence of mental distance from one's job, or feelings of negativism or cynicism related the job) and *reduced personal accomplishment* (a sense of ineffectiveness and lack of accomplishment).

There are disputes concerning the definition of cut-off values and relevant dimensions for burnout. This results in discrepancies in recent review materials with the prevalence of burnout ranging from 0% to 80.5% (6, 7, 13, 76). Researchers Rotenstein et al. and Hiver et al. point to a lack of consensus in the definition of burnout and a lack of standardised measurement tools precluding a reliable investigation (7, 76). Hiver calls for a standardised method to assess burnout prevalence in the medical community in a systematic review investigating burnout prevalence among European doctors from 2022 (7). However, in Rotenstein et al.'s work, ten of the studies reported on overall burnout prevalence in a congruent manner resulting in somewhat more reliable estimates ranging from 25% to 60% in prevalence of burnout among groups of doctors.

MBI has become a 'gold standard' to measure burnout, but there are also multiple other tools designed to measure burnout, such as Astudillo and Mendinueta Burnout Questionnaire, Burnout Assessment Tool, Modified Compassion Satisfaction and Fatigue Test, Copenhagen Burnout Inventory, Hamburg Burnout Inventory, The Pines and Aronson Burnout Measure, and Zero Burnout Program Survey (61, 76, 82).

The Scandinavian countries have similar health care systems and matching medical professional work cultures, thus Scandinavian research is relevant in the Norwegian perspective. In a study of Danish GPs, one in ten met the criteria for burnout syndrome in 2018 (83). Åsberg et al. found a that the increase of sick leave among doctors in Sweden in the period 1997–2003 was largely due to stress-induced mental illness (84). Further, stress-related conditions such as emotional exhaustion and burnout are among the most common diagnoses in long term sick leave in the general population in Sweden.

Depression, suicide

Occupational stress is associated with burnout in doctors and burnout and depression are found to overlap (85, 86). In particular, emotional exhaustion has a high shared variance with depression. In a cross-sectional study from 2016 of more than 6000 Austrian doctors, Wurm et al. estimated that approximately 10% of doctors suffered from major depression and an estimated 50% suffered from burnout (87). More than 80% of the depressed doctors in Wurms' study also suffered from symptoms of burnout. Wurm found that the burnout measures emotional exhaustion, personal accomplishment, and detachment tend to correlate highly with sadness, lack of interest, and lack of energy, all symptoms of major depression. Internationally, doctors have a relatively high prevalence of depressive symptoms compared to the general population (4, 88-91). In a world-wide systematic review by Mata et al. from 2015, studies involving a total of 17,560 individuals were included to investigate the prevalence of depression or depressive symptoms among resident doctors (89). Residency normally coincides with the first years after medical school which seems to be a particularly stressful time often coinciding with establishing a family and buying a first home (4, 92, 93). Mata et al. found a summary prevalence of 28.8% of depressive symptoms ranging from 20.9% to 43.2%, depending on the instrument used.

Perceived job stress, particularly interruptions during work and high time pressure are related to suicidal thoughts (94). Job stress, increased occurrence of burnout, and

depression put doctors at a higher risk of suicide than the population in general (88, 90, 95-97). A systematic review by Dutheil et al. from 2019 found that female doctors are at higher risk of suicide compared to females in the general population, than male doctors to males in the general population. Doctors working in the US were at higher risk than European doctors (98). Dutheil calls for preventive measures to reduce these suicide rates. Fortunately, suicide rates have decreased within the profession over time (98), in Europe in particular, however, these numbers do not include the consequences of Covid-19, which is thought to present additional suicide risk to health care workers in particular (99, 100).

With high reported symptom pressure of burnout, depression, and suicidal thoughts among doctors, we need to know about their help-seeking behaviour or the lack of it.

Help-seeking behaviour among doctors

'…the tide against the stigma of mental illness generally, and mental illness among doctors, is finally turning'. Gerada, 2019 (101)

Doctors' reluctance to seek professional health care when faced with mental health problems has been well documented. There might be several reasons for this, some based on rational reasons such as availability of services, fears about confidentiality, and fears of clinical competence being questioned (102). Other less rational reasons are often dictated by the hidden curriculum (49-55, 103, 104), such as shame, denial, and reluctance to adapt to the role of a patient (22, 23, 102, 105, 106).

In a cross-sectional study, Gaerlick et al. investigated self-referred doctors to the MedNet programme (30). MedNet was a face-to-face, psychotherapeutic assessment service for doctors in London and South-East England. Today the service is replaced by the Doctors' Support Network. MedNet intended to target doctors without formal psychiatric problems. Even so, the study found high levels of distress and a significant proportion of doctors with risk of suicide among those attending the service. However, low rates (9%) suffered from severe psychiatric illness. Gaerlicks' study thus indicates late help-seeking behaviour.

In a qualitative study from 2021, Riely et al. researched British junior doctors' experiences of protective factors and sources of support at work (107). Their analysis identified three main areas concerning protective factors in the workplace that enable support: 'support from work colleagues – help with managing workloads and emotional support; (2) supportive

leadership strategies, including feeling valued and accepted, trust and communication, supportive learning environments, challenging stigma and normalising vulnerability; and (3) access to professional support – counselling, cognitive–behavioural therapy and medication through general practitioners, specialist support services for doctors and private therapy'.

In recent years mental issues and illness have been more openly discussed, hopefully contributing to reducing the stigma attached to also seeking professional healthcare when mentally ill (59, 101). We know doctors turn to peer support for help, thus we need to know more about beneficial effects of such services.

Relationship between peer support and improved well-being

There are few studies investigating the effect of peer support on doctors. However, several studies investigate various interventions for professional health care workers, including doctors, such as stress management training classes (77), professional coaching interventions (64), self-administered psychotherapeutic tools (70), self-care workshops (69), mindfulness (71), and group exercise programs (80). These findings are not consistent and show varying effect as measured by MBI. Whilst some report promising results in reduction of burnout, others do not find any change. In a systematic review and meta-analysis studying interventions to prevent and reduce doctors' burnout, West et al. calculated an overall reduction in burnout from 54% to 44% with a variety of approaches (17).

Few studies have assessed long-term post-intervention effects. In a study by Rowe et al. over a hundred health care professionals, among them 10 doctors/surgeons, were divided into three groups (two intervention groups, one control group) (77). The intervention groups attended a six-week training program in professional stress management. Follow-up measures were carried out at two and six months after training. Subjects in the groups who had received stress management were significantly less burned out than subjects in the control group. The control group demonstrated no differences in the scores across time.

Research conducted in Norway demonstrated that doctors who attended peer support exhibited significantly better mental health even up to three years after the intervention (35, 42, 43). The longitudinal study documents a decrease in levels of burnout, job-related stress, as well as symptoms associated with depression and anxiety. This suggests that peer support services may play a significant role in promoting well-being.

Interventions for doctors

'Peer support' is a term that is usually understood from a patient perspective as support from a person who has knowledge from their own experiences with a condition. In the widest sense of the word 'peer support' can be described as something that ' …involves people sharing knowledge, experience or practical help with each other' (33).

Organised occupational peer support has its roots in the 1970s US police force (108). Traditionally, peer support for doctors consisted of informal, low-threshold collegial conversations, and this form of support is still very much in use through day-to-day mentoring and collegial discussions. In the wake of reports of mental ill health, increased suicide rates, and a growing concern for doctors' well-being in the early 1980s, several low-threshold peers support services were established (109). The first specific programs for doctors – Doctors Health Programs (PHP) – were instituted in the US, and were treatment programs aimed at preventing malpractice behaviours, mainly related to drug and alcohol misuse (110, 111). The PHPs will not be further discussed in this thesis, as I have chosen to focus on peer support, but from the PHPs, peer support services without formal treatment evolved. Today, professional peer support services are offered to doctors in need of advice, regardless of their present situation. Many of the peer support programs are anonymous services run by voluntary doctors and practice a strict confidentiality only to be breached if an individual's safety is at risk (112-115). Web and literature searches give the impression that these professional services are, as of now, limited to more developed parts of the world. In some countries, as a result of Covid, establishment of peer support services has accelerated due to the exposure of societies' vulnerabilities when facing a highly contagious disease, and our collective dependance upon keeping doctors at work (67, 100, 116).

After going through many of the peer support services offered to doctors, in general, they offer anonymous help, free of charge. How the services are organised varies widely but can be roughly divided into services that have 'professional peers', such as employed psychiatrists, and voluntary peers. They all offer an arena for confidential dialogue. Several countries offer specific support to doctors who are under investigation by a Medical Council. A few of the US services operate by peer support outreach. Many of the services facilitate interventions and refer to medical treatment if necessary.

Norway has a comprehensive offer to doctors seeking peer support. Through the Norwegian Medical Association, both a centralised service centre, Villa Sana, and a locally-based service with local peers (Støttekollegaordningen) offer support (117). Since 2019, there is also a free and confidential offer to doctors struggling with drug or alcohol misuse at the substance abuse clinic Trasop (118). All three services are accessible free of charge to all doctors working in Norway. Both the services at Villa Sana and the local peer support service are described in detail in the Chapter 4. The service at the substance abuse clinic Trasop aims to survey the doctor's addiction and mental health, and then make suggestions for further treatment. No referral is necessary, and the offer entails 1-5 free sessions based on individual assessment (118). This service will not be further discussed in this thesis.

The services listed in the following table are not to be thought of as an exhaustive list, but rather as an indication, perhaps, of where such services are easily accessible and prioritised, and to give a glimpse into what they may offer.

Table 1, examples of peer support services for doctors

Continent	Service	Target groups	Interventions	Ref.
US	University of California Caring for the caregiver	All health care team members experiencing the second victim effect	Phone or meet in person. One time event or with an occasional follow-up. Confidential Free of charge	(119)
	Brigham and Women's Hospital Peer Support Program	Clinicians and other Brigham faculty	Trained peers reach out to impacted colleagues	(31, 40, 56)
	Stanford Physician Resource Network (PRN)	Doctors after facing an adverse effect	Confidential Anonymous Legally-protected Trained peers reach out to impacted colleagues	(120)
	Mayo clinic HELP program Office of Staff Services free of charge	Mayo Clinic Employees	Crises text line Programs on stress management and resiliency training Mindfulness in medicine Practicing gratitude. Benefit counseling Resource and referral services	(38, 121)
	The Physician support line	All students and doctors in the US.	Help line operated by 600+ volunteer psychiatrists	(122)
Canada	Doctors Nova Scotia The Professional Support Program	Doctors and their family members, doctors under investigation.	Help line Confidential Referrals	(123)

	The Physician Navigator Program		Guidance and moral support on what to expect Free of charge	
	Alberta medical association / PFSP (Physician and Family Support Program) P4P (Physicians for Physicians) (P4P)	Students and doctors	Help line Confidential Network of family physicians who are willing to take colleagues as patients	(124)
	Quebec physicians' health program / peer support program	Doctors	Counseling Referrals	(125)
Australia	DRS4DRS	Students and doctors	Help line Network of doctors' health and referral services Confidential Mental health support service Trained and experienced psychologists, and counsellors Free of charge	(126)
	AMA Victoria Peer Support Service	Students and doctors	Help line Anonymous Confidential The cost of a local call	(113)
United Kingdom	BMA peer support service, counselling service, DocHealth	Students and doctors	Help line or video call Confidential Consultation Not for profit service Delivered by psychotherapists Fees varying depending on the circumstances of the doctor	(112, 127, 128)
	WARD	Junior doctors	Help lines	(129)
	Doctors' Support Network	Doctors with mental health concerns	Online Support Forum Anonymous Confidential	(115)
	Doctor Support Service	Doctors under investigation by the General Medical Council	Help line, may accompany to hearing. Confidential	(130)
	British Doctors and Dentists Group	Doctors in recovery of addiction	Self-help group	(131)
	Sick Doctors Trust	Doctors in recovery of addiction	Help line Anonymous The cost of a local call	(132)
	NHS confidential staff support line	NHS colleagues	Text support service Confidential	(133)
	Trainees4trainees (T4T)	For Thames Valley healthcare workers in postgraduate training across specialties	Online support group Videoconference Group of 10 participants 2 facilitators 45 minute sessions per	(134)
Ireland	Royal College of Physicians of Ireland. Mentoring	Doctors	Mentoring initiative Confidential Free of charge	(135)
Spain	Colegio de Médicos	Doctors	Preventive interventions Self-referrals to in- and outpatient treatment (PHPs)	(110, 136)

Denmark and Greenland	Kollegialt Netværk for Læger	Doctors	Counselling Anonymous Confidential Free of charge	(114, 137)
Finland	Doctors for doctors	Doctors	Counselling Referrals Confidential Free of charge	(138)
Sweden	Kollegial rådgivning	Doctors	Counselling Anonymous Confidential Free of charge	(139)

The Norwegian context

Medical professionalism

Norway has a long history of doctor's unions and a longstanding tradition of public monopoly that is founded on the principle of equity. The Norwegian medical society was established in 1833 and The Norwegian Medical Association was established 1886 (140, 141). Norwegian doctors have historically been well-organised, well-respected, and valued members of society. However, increasing regulations of professional duties combined with increasing patient rights have gradually limited the professional autonomy in a shift towards a consumer model in the health care system (46, 142, 143). From a Swedish study, we know that regulations and reforms may be perceived by health workers as both limiting and as supporting by creating greater clarity and direction (144).

Since the establishment of the Institute for Studies of the Medical Profession in 1995, studies with representative samples of Norwegian doctors demonstrate that the majority are healthy, satisfied, and proactive (145). Norwegian doctors have historically reported high job satisfaction (146-148). They live long lives and remain active outside their profession (149). However, there are some concerns, and the steady satisfaction reported by the Norwegian doctors has declined since 2010 (148, 150). Seen in combination with the increase in applicants to the Norwegian peer support services for doctors, considerable media coverage of challenges in doctors' work-home balance, the reported increase in work-related stress, and difficulty in recruitment of doctors in recent years indicate cause for concern (148, 151-155).

Doctors mental distress and burnout

In a study based on repeated surveys, Rosta et al. demonstrated that job satisfaction for Norwegian doctors decreased from 2010 to 2016–2017 (150). The decrease was significant for general practitioners (GPs) and hospital doctors, but not for private practice specialists.

In studies by Langballe, Innstrand et al., gender differences in burnout within and between eight comparative occupational groups were studied (60, 147). Burnout was measured by a Norwegian version of the Oldenburg Burnout Inventory (OLBI). They found that female doctors reported fewer work hours, lower levels of disengagement, but higher levels of exhaustion compared to their male colleagues. The male doctors reported the highest average working hours per week among the eight professional groups. This study found that the medical profession may be more prone to burnout than other occupational groups, but have similar burnout levels to Norwegian priests and lawyers.

Hertzberg et al. studied job-stress and emotional exhaustion using data from NORDOC (The Longitudinal study of Norwegian Medical Students and Doctors) (46). Hertzberg concludes that lack of reduction in work stress and challenged work-home balance are important predictors of high emotional exhaustion, often described as the most important dimension of burnout. Earlier studies of the NORDOC data demonstrate variations in work-home stress throughout the career: Doctors report an increase in work-home stress the first years after graduation followed by a reduction after 10 to 15 years (92, 93). To many doctors, the years of internship and residency coincide with establishment of family life and personal financial obligations, which may add strain to the balance between work and home life. Røvik et al. also hypothesised that stress related to medical competence will decrease as experience increases over the years of practice (93). Indeed, their results demonstrate a significant decrease in emotional pressure, time pressure, and fear of complaints over the course of ten years following the final year of medical school.

A study from 2000 by Falkum investigated the prevalence of burnout among Norwegian doctors. By the use of MBI, Falkum found a score of 3% burnout, when applying strict criteria pertaining to all the three dimensions of the MBI (156). But in the same survey, 41% of doctors felt that they worked too hard, and 39% reported exhaustion at the end of the workday. 29% scored higher than cut-off on the emotional exhaustion dimension. As well as reduced job satisfaction, Rosta et al. found an increase in job stress among Norwegian

doctors measured by multiple surveys from 2010 to 2017 (148, 157). Rostas' findings thus indicate reasons to assume that Norwegian doctors are increasingly in risk of becoming unwell today, in 2023.

Depression, suicide

Falkum found a relatively high correlation between emotional exhaustion and depression in his studies (156). With data from the Norwegian Physicians' Survey, Tyssen found that depression and suicide are more prevalent among doctors than in the general population (88). Tyssen connects these finding to lack of autonomy, job stress and demanding patients. In a prospective study on suicidal ideation, Tyssen et al. document a prevalence of suicidal ideation of 14% and a life time prevalence of 43% among medical students and young doctors in Norway (94).

Help-seeking behaviour among doctors

In 2002, Rosvold et al. (158) found that 75% of doctors in Norway reported that they had self-medicated during the last three years, using data from the Norwegian Medical Association's health survey. They concluded that most Norwegian doctors practice self-treatment when they are ill. In a prospective cohort sample of Norwegian medical students and young doctors, Tyssen found that 34 % reported that they needed treatment for mental health problems on one or several occasions, among these 72 % sought treatment, but with a trend of decreased help-seeking over time (105). This is in accordance with the afore-mentioned international literature showing inappropriate health care use among doctors.

However, Norwegian doctors do seek peer support. Regarding attendance to the peer support services, Rosta and Rø found that, in 2019, 5.8% of senior doctors and 4.9% of resident doctors reported having used the local peer support service at some point: 9.1% of senior doctors and 1.6% of resident doctors had been to Villa Sana for counselling, and 4.3% of senior doctors and 0.8% of resident doctors stated that they had attended courses at Villa Sana (157). Numerically, more than 5,500 doctors have attended Villa Sana since it opened in 1998. In 2023, there are approximately 30,000 doctors in Norway (159).

In a paper named 'Does a self-referral counselling program reach doctors in need of help? A comparison with the general Norwegian doctor workforce', Isaksson Rø et al. has studied doctors attending Villa Sana using psychometric measures (59). They found that in

comparison to all Norwegian doctors, doctors who attended Villa Sana demonstrated high levels of emotional exhaustion, symptoms of depression and anxiety, as well as work-related stress. 61% of the doctors who attended Villa Sana did so due to burnout and exhaustion (35, 43). These findings suggest that the service at Villa Sana effectively reach doctors who require support.

Relationship between peer support and improved well-being

A study from Norway described improved mental health among doctors up to three years after attending peer support service at Villa Sana (35, 43). The longitudinal study reported a reduction in levels of burnout, job stress, and symptoms of depression and anxiety (35, 43). This indicates that peer support services may contribute to increased doctor wellness.

Peer support has also been studied qualitatively, from the peer supporters' point of view in the locally based peer support service (160, 161). The research discusses the relationship between support and surveillance in the service, as well as the peer supporters' views on the service they provide. The studies reveal that peer supporters need to acknowledge the balance between the formal and informal aspects of the support they give. The peer supporters describe their role as attentive and supportive. They emphasise the value of the framework of the service, which includes easy accessibility, a prompt offer of up to three consultations, a high degree of confidentiality, and informal contact.

Another intervention, on medical students' well-being, has also been researched in Norway. De Vibe et al. studied the effect of a seven-week Mindfulness-Based Stress Reduction (MBSR) program on medical and psychology students. Measuring mental distress, study stress, burnout, subjective well-being, and mindfulness they found a moderate effect on mental distress as well as increased well-being following the intervention (162).

Norwegian studies thus demonstrate that doctors make use of the peer support services offered, and that there are beneficial effects of attending peer support (59, 152).

There is reason to address the topic of help-seeking among doctors as they report high levels of distress, burn out, and depression. Doctors are reluctant to seek health care, and tend to practice self- treatment. Research points to perceived decrease in job satisfaction and increase in work stress. Added to personal suffering when unwell, doctors' ill health also influences quality of patient care in a negative manner. We therefore need to expand our

knowledge of when and why doctors seek help, what they need, and what they get when attending peer support.

Chapter 2 Aims of the Thesis

The overall objective of this thesis is to study the experiences of doctors who have attended peer support in a short term (10 days) and a long term (one year) perspective. This is done by three qualitative studies of doctors who sought peer support. The research attempted to capture their reflections, their understanding, and their experiences. Our aims were as follows:

- How do doctors reflect on why and when they seek peer support? What kind of help do they expect to receive and what factors enable or restrict help-seeking? (Paper I, III)

- What types of changes do doctors report a year after receiving peer support? (Paper II, III)

- How can peer support facilitate awareness of and promote changes in professional cultural values that can help doctors to self-care? (Paper II)

- What do the doctors say about how various elements in the peer support services' design impact if and how they benefit from it? (Paper II, III)

Chapter 3 Key concepts and theoretical perspectives

Placing the study in a research field

'Human behaviour cannot be understood without references to the meanings and purposes attached by human actors to the activities' Guba and Lincoln (163).

The philosophy of science underpinning this study is that reality is shaped by each individual perceiving it, whilst prevailing factors arise and are shaped by the social and cultural contexts where they happen (163-165). To investigate how people understand and experience something, qualitative interviews are a useful approach (166-168). Qualitative studies will often involve a process of constructing meaning from the empirical data and will often emphasise the importance of understanding the perspectives and experiences of the individuals being studied. The qualitative perspective can by summarised as follows (165, 168-171):

- meaning is created, appears, and can only be understood in a connection or context.
- in all interpretation and understanding, parts depend on the whole, and vice versa.
- all understanding presupposes some form of pre-understanding.
- any interpretation is preceded by expectations or preconceived notions.

Theoretical context of organisational culture and leadership

Early in the analytical phase of the second set of interviews (the empirical data Paper II is based on), it became clear that several of the interviewees attributed an important part of positive changes in their lives to the peer support they had received. We sought theoretical approaches that could shed light on change common to members of the same professional group. Organisational culture turned out to be a helpful concept to further understand these processes.

Culture has been studied, modelled, and defined for a long time and in numerous ways. Organisational culture consists of shared values, perceptions of reality, and shared norms between individuals in an organisation, either related to work or other activities. These norms can take the form of formal organisational structures, such as written laws and business plans, but they can also be unwritten and describe ways of conversation, patterns

of behaviour, or normative beliefs about how things are or should be. In this thesis, the definition and model of organisational culture constructed by psychologist Edgar Schein is used as a theoretical lens, providing structure and context to the understanding of change processes among the doctors who sought peer support (172).

The choice of theory was inspired by a compelling article, 'Healing the Professional Culture of Medicine' from 2019, written in cooperation between Schein and Tait Shanafelt, a prominent researcher in the field of physician health (78). The article discusses the culture of medicine, both in light of Schein's understanding of culture as well as pointing to unhealthy behavioural consequences of the so-called hidden curriculum in medicine (78).

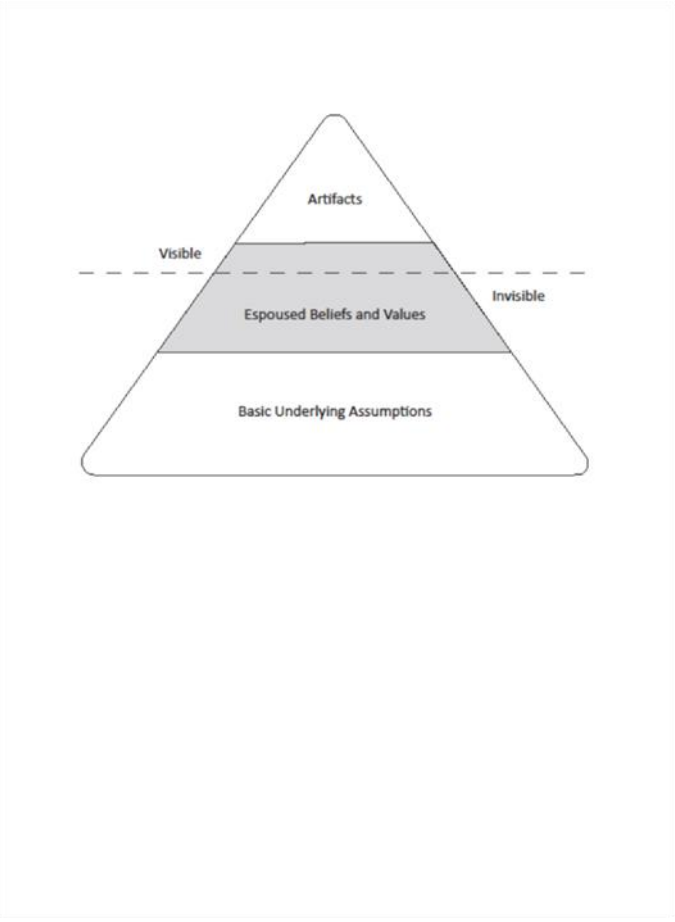
Schein's definition of culture applies to organisational cultures as well as professional cultures, such as medicine, that entail strong socialisation processes during the education and training period. He defines these cultures accordingly: 'The culture of a group can be defined as the accumulated shared learning of that group as it solves its problems of external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel, and behave in relation to those problems. This accumulated learning is a pattern or system of beliefs, values, and behavioural norms that come to be taken for granted as basic assumptions and eventually drop out of awareness' (172).

According to Schein, organisational and professional culture can be defined by a number of elements that interact at different levels of observability, see figure 2. The complex relationships between observable and less observable elements have been simplified by Schein, and organised into three main levels of observability, namely artifacts, espoused values and beliefs, and basic taken-for granted assumptions (172).

Artifacts can be physical, behavioural, or verbal manifestations of an organisation or profession and its culture. According to Merriam-Webster, one definition of artifact is 'something characteristic of or resulting from a particular human institution, period, trend, or individual' (173) Schein defines the artifacts in a wide sense as what you see, hear, and feel when you encounter a culture (172). Examples of physical artifacts are dress codes, logos, or other material objects. For doctors the white coat and the stethoscope are examples of artifacts. Behavioural artifacts can be ceremonies and traditions. Verbal artefacts can include anecdotes, figures of speech, narratives, or metaphors. Schein and

Shanafelt together use a narrower definition of artifact: Behaviour. One example they use is that doctors work excessive hours and often do not take care of themselves in terms of diet, exercise, sleep, and preventive health care (78). In the theoretical perspective applied in Paper II, the understanding of artifacts is limited to, and referred to as *actual circumstances*, such as employment, sick leave, attending therapy etc. By comparing interviews conducted in 2018 and in 2019 (Paper II) and identifying artifacts, the theory became a tool used to expose change processes as reported by the interviewees, for example a reduction in numbers of working hours per week.

Figure 2, Adaptation of Schein's three levels of organisational culture (172)



Espoused beliefs and values are central principles that define what kind of behaviour is expected and accepted in the given professional setting or organisation. According to Schein, these include ideals, values, and aspirations, or what is considered to work or not work in a profession. The espoused beliefs and values may be visible, such as ethical guidelines for doctors or invisible, such as the hidden curriculum. Schein and Shanafelt define espoused values as 'what we say we do' (78). An example of a visible espoused value is the belief that self-care is important (78). In Paper II one such partly visible, partly invisible belief reported was that having a mental illness is incompatible with the role of a doctor. Shared values and beliefs may ultimately over time gravitate into shared assumptions and thus form the basis of norms and the basic taken-for-granted assumptions.

The basic taken-for-granted assumptions lie at the deepest level of an organisational or occupational culture. It is also referred to as 'the cultural DNA' and determines thoughts,

feelings, perceptions, and behaviours (172). According to Schein, 'when the same solution to a problem works repeatedly, it comes to be taken for granted …. gradually becomes treated as a reality' (172). These are assumptions and convictions that will often be unconscious, and which influence what is perceived and emphasised by people in the organisation. Examples of basic assumptions can be beliefs about how to define what is true and real. When basic taken-for-granted underlying assumptions are identified, it is easier to interpret the artifacts and espoused values and beliefs when the culture expresses itself. Schein and Shanafelt refer to the basic taken-for-granted assumptions as 'what it reveals': On the one hand, doctors say that self-care is important, on the other, they do not attend to their own health. This reveals that to doctors 'self-care is not important' (78) and as a doctors you are supposed to be made from the human fabric that does not become sick. In Paper II we expose that attending peer support may have contributed to changes in basic taken- for - granted assumptions towards a view of doctors as where a dimension of being vulnerable is also part of being a human being.

Scheins' perspectives on medical professional culture may therefore be useful in relation to what kind of help doctors appreciate and use and what elements are important in order to facilitate change. After defining culture in his work on organisational culture, Schein moves on to consider how positive cultural change can be implemented into an organisation or workplace. He discusses how learning anxiety must be reduced and the crucial need for presence of psychological safety to attain such change.

Psychological safety

The phenomenon 'psychological safety' was first explored by organisational scholars in the 1960s, a pioneer being W. Kahn (174). It is a multifaceted term, as its presence in an organisation is thought to have a large number of positive consequences that includes facilitating 'to share information and knowledge, speak up with suggestions for organisational improvements, and take initiative to develop new products and services' (175), thus enabling improvement and new learning in a workplace.

The definition of the term by Edmondson is used in this thesis: 'Psychological safety describes perceptions of the consequences of taking interpersonal risks in a particular context such as a workplace' (175, 176). It is important because it allows individuals to feel comfortable expressing their thoughts and ideas, and enables them to take risks without

fear of negative consequences. This can lead to increased creativity, innovation, and productivity within a group or team. It can also improve mental health and well-being, as individuals feel more supported and less isolated. To achieve psychological safety at a workplace, according to Schein, employees must first feel that a change is in their own interest and that the interpersonal risk in engaging is low. To achieve this, he suggests several activities including providing positive role models (especially on higher levels at the workplace), support groups in which learning problems can be discussed, and a focused dialogue. In this context, Schein defines dialogue as 'conversation that allows the participants to relax sufficiently to examine the assumptions that lie behind their thought processes', which have obvious similarities with peer support counselling (177).

Considering this knowledge, we found it useful to apply the theoretical lens of psychological safety to inform and interpret the material presented to us. Psychological safety interacts with negative aspects of the 'hidden curriculum' as the latter dictates that doctors should endure, not showing weakness (thus not speak up) and so forth (50, 51, 78, 104).

The hidden curriculum

'Strangely, there is no place for mistakes in modern medicine. Society has entrusted doctors with the burden of understanding and dealing with illness. Although it is often said that 'doctors are only human,' technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection'. (178)

The term 'hidden curriculum' was reportedly coined by Philip W. Jackson in his book 'Life In Classrooms'1968 and the first formal definition of the hidden curriculum in medical literature appeared in a paper by Hafferty in Academic Medicine in 1994 (53, 179). The term 'hidden curriculum' seems to lack a distinct and universal interpretation in medicine and has been defined and operationalised in many different manners; a few papers even review its different definitions (51, 54). The 'hidden curriculum' is often understood as promotion of a culture of infallibility by norms dictating lack of self-care, such as always putting work first. However, in this thesis the term is understood as a neutral, descriptive concept entailing both negative and positive aspects as outlined by Hafferty in his original paper: 'Most of what the initiates will internalise in terms of **values, attitudes, beliefs and related behaviours deemed important within medicine** takes place not within the formal

curriculum but via a more latent one, a “hidden curriculum”, with the latter being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques' (51, 53). The hidden curriculum in medicine can include the values and beliefs that are emphasised by the medical education system, such as the importance of professionalism, competence, and empathy. It can also include the norms and expectations of the medical profession, such as the importance of following protocols and guidelines, and the need to prioritise the needs of the patient over the need of health care workers. It is also thought to include a range of attitudes and values, such as the prioritisation of technical skills and scientific knowledge over empathy and communication, the emphasis on individual achievement and competition over teamwork and collaboration, and the value placed on certain specialties and subspecialties over others.

Hafferty describes a curriculum that functions at the level of organisational structure and culture in medical education (49). However, this thesis does not specifically investigate the 'hidden curriculum’s' more positive influences, such as doctors’ professional identity formation and enforcement of best practice (49, 54), rather it looks into the resulting development of a 'common' professional identity among doctors (180).

Bennet points out that while the term is most commonly used in connection to medical education, it is also present as 'a hidden and powerful curriculum that affects doctor performance' throughout a practice lifetime (49). Here it may advocate maladaptive behaviours such as inappropriate self-treatment and sickness presenteeism (12).

The 'hidden curriculum' as a theoretical lens is useful in deepening the understanding of an issue that is consistent in research on doctors’ health: Doctors reluctance to seek help. As this thesis studies doctors’ handling of their own mental health and self-care through attending peer support, it was anticipated that the aspects of the hidden curriculum were relevant to the study, for example: Doctors should not complain about the number of hours they work, if they do it is an expression of a lack of commitment to the profession (104).

Together, theories on organisational culture, psychological safety, and concepts of the hidden curriculum form a basis for understanding and analysing doctors’ behaviours when seeking (or postponement of seeking) peer support and their subsequent changes in behaviour. Working with this thesis, theoretical perspectives were introduced in continuation of the first article that describes a hesitance and delay in help-seeking. The

values, attitudes, beliefs, and related behaviours described as important within medicine by the hidden curriculum and, as forces shaping organisational cultures, proved useful to interpret the empirical material in the following two papers. Theory on psychological safety added further value to the empirical material by identification of aspects that need to be in place for peer support.

Peer support services for doctors can be a natural venue for discussing medical culture and professionalism. The confidentiality of these services is meant to provide psychological safety. With its approach, peer support can enable asking questions about and discussion of the hidden curriculum and challenging organisational aspects in a work environment.

Chapter 4 Research methods

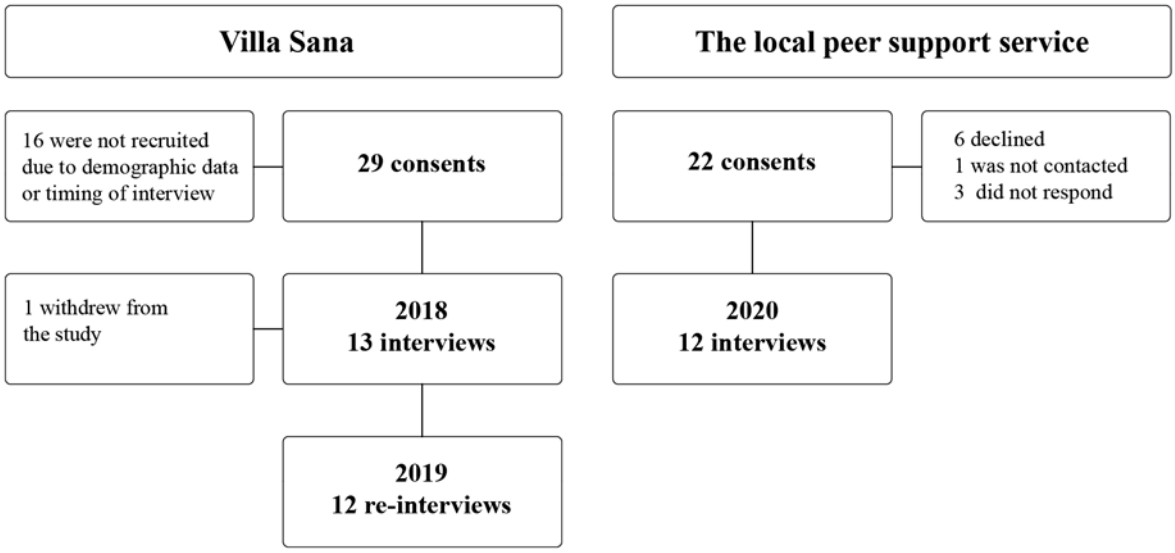
The study design

This thesis was set in two different services offering peer support to Norwegian doctors, Villa Sana and the local peer support service Støttekollegaordningen, see figure 3. Villa Sana is a centralised support service for all Norwegian doctors, and Støttekollegaordningen is a local peer support service found in each county in Norway. These services are designed to be easily accessible, low-threshold services, and to offer 'empathic support, advice, and counselling' (117). For both services, expenses are covered[1] by The Sickness Compensation Fund for doctors (SOP) (181). The fund is managed by the Norwegian Medical Association. All doctors in Norway can use the services – they do not need to be members of the Medical Association.

This thesis is composed of three papers with a qualitative research approach based on individual interviews of 25 doctors who have attended peer support. 12 of the doctors were interviewed twice with a year in between, thus 37 individual interviews were performed. The interviewees all possessed the specific characteristics required to answer the study's research question, namely attendance of a peer support service for doctors. Thus, 25 informants should be sufficient to ensure informational power (182).

[1] In 2023 SOP introduced a deductible of 3,000 Norwegian kroner for the courses at Villa Sana, and limited the number of visits to the service to one per year.

Figure 3, overview of interviews



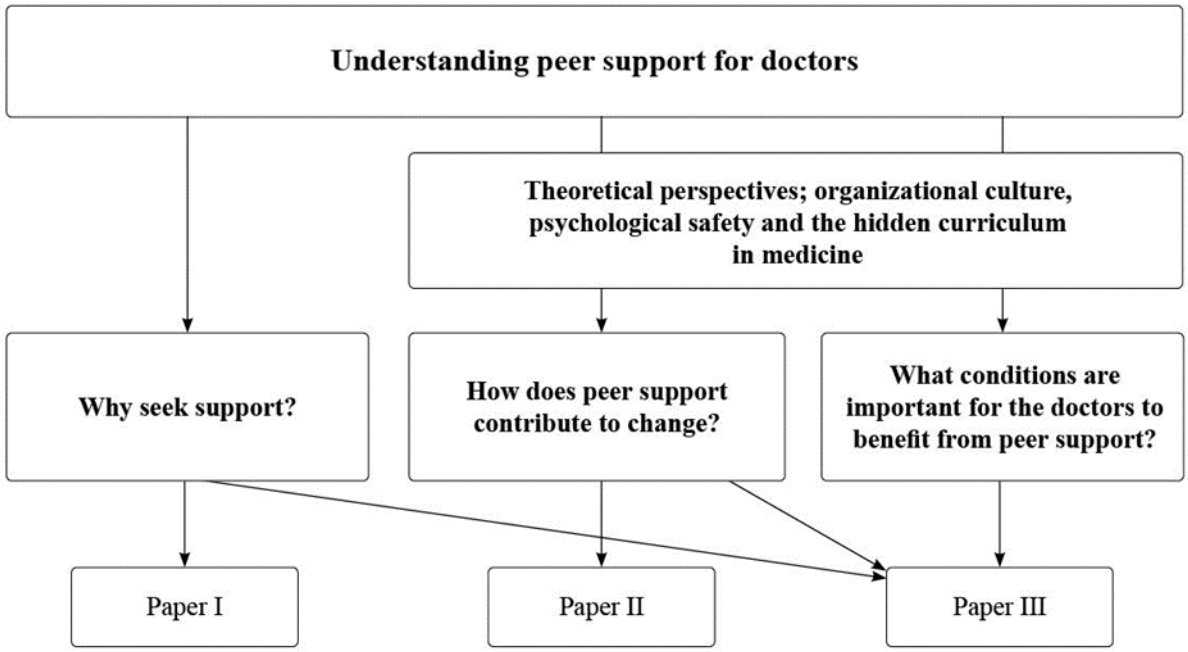
Paper I is based on 13 interviews. The empirical material was collected within 10 days after the interviewees had attended peer support at Villa Sana. Collection took place in 2018.

Paper II is based on 12 re-interviews of the participants in Paper I. The empirical material was collected a year (+/- 30 days) after attendance to Villa Sana and seen in comparison to the empirical material collected for Paper I, a total of 25 interviews. Collection took place in 2018 and 2019.

Paper III is based on 12 interviews. The empirical material was collected a year (+/- 30 days) after attendance to Støttekollegaordningen/the local peer support service. Collection took place in 2020.

Figure 4 gives an illustration of how the three papers contributed to answering the different aspects of understanding peer support for doctors.

Figure 4, overview of the thesis



12 of the doctors were interviewed twice, which represents a longitudinal qualitative interview approach (LQI). According to Hermanowicz, LQI is conduction of interviews 'with the same people over a time period sufficient to allow for the collection of data on specified conditions of change' (183). This may allow the researcher to expose and evaluate process (183).

Setting and participants Paper I and II

Villa Sana

Villa Sana is a centralised peer support service centre. The centre was established in cooperation between the Sickleave and retirement compensation fund/the Norwegian Medical Association and the psychiatric hospital Modum Bad in 1998, due to worrisome international reports of doctors' suicide rates, high rates of burnout, and reluctance to seek medical advice when in need. The service is not designed to provide medical services, i.e., no medical records are kept, and no sick notes or medical prescriptions are provided. Villa Sana has, since then and until 2022, been used by more than 5,500 help-seeking doctors, and numbers have been increasing every year (152). The expressed aims of the service at Villa Sana are to strengthen professional identity, enhance health and life quality, and to prevent

burnout (75). As representatives for the peer support service at Villa Sana are often asked to speak to different groups of actively working doctors, the experiences from the peer support service may contribute to normalising ill mental health and help-seeking behaviour in the Norwegian medical profession.

Villa Sana offers two types of interventions: a single-day counselling session (six hours) with a trained mental health professional, and a group-based, week-long course for 8–10 doctors.

In the single-day counselling session, the doctor's life situation and steps needed to handle it are discussed. This can include advice on seeking formal medical treatment including psychotherapy, although no formal action is taken. The counsellors are either psychiatrists, specialists in psychology or occupational medicine.

The course includes boarding, daily lectures, discussion, and physical activity and an individual counselling session of 45 minutes. Themes of the lectures are possibilities and restraints in work life, doctors' resources and personality, emotional awareness, mindfulness, identity, communication, teamwork, and prevention of burnout (2, 181). In addition, the centre offers sessions and courses for couples, where one or both partners are doctors.

Participants

For the first set of participants (Papers I and II), a purposeful sampling strategy was used. We aimed at recruitment of a sample that represented the doctors visiting Villa Sana (166). We opted to achieve this by recruiting participants according to sex, a variety in specialties, variety in ages and in work experiences in the fall of 2018. This was a personal recruitment process where counsellors were involved and asked those attending Villa Sana if they wanted to take part in the study. There was an emphasis on recruiting participants from all the different counsellors and from different courses in the recruitment period, during the fall of 2018. More female than male doctors were recruited, as approximately 70% of doctors attending Villa Sana are female (184). We recruited general practitioners and hospital doctors in proportion to the number in Norway (159). We recruited according to the average ages of doctors attending Villa Sana in 2017, please see table 2.

Table 2, demographic data 2018 and 2019 (-1)

Characteristics of the selected participants (n = 13)	Participants (n)
Gender	
Male	4
Female	9
Age (average 42 years)	
60 – 70	1
50 – 60	2
40 – 50	4
30 – 40	5
20 – 30	1
Medical specialty	
Family medicine	4
Surgical specialties	3
Laboratory medicine	2
Psychiatry	1
Internal medicine	3
Work experience	
0 - 10 years	4
10 - 20 years	5
20 - 30 years	3
30+ years	1

The participants were interviewed twice with a year between interviews. For the second interview, one female aged 30-40 years, working in family medicine with a work experience of 0-10 years withdrew from the study.

Setting and participants Paper III

Støttekollegaordningen/the local peer support service

The local peer support service is a network based in each of the eleven counties in Norway. It includes approximately 90 dedicated peer supporters. The service markets itself as 'an outstretched hand from colleague to colleague' (117). On the homepage of the Norwegian Medical Association, contact information such as the names, e-mail addresses, phone numbers, towns of residence, and medical specialties of the peer supporters is accessible. The service offers up to three counselling sessions with a peer, and the peer receives monetary compensation from the SOP. Peer supporters guarantee confidentiality and retain full discretion regarding the information with which they are entrusted. The doctors seeking support freely choose the peer supporter they want to reach out to, and can also choose a peer supporter in another county. The service is not designed to provide medical services, i.e., no medical records are kept, and no sick notes or medical prescriptions are provided.

Guidelines on the peer support role are described in further detail in an information booklet for peer supporters published on the Norwegian medical association web page (185).

Participants

Peer supporters at the local peer support service are invited to a yearly conference where they discuss experiences and get professional input. I presented the research project and invited the peer supporters to give feedback on it in the winter of 2018. They were told that they would be asked to hand out a letter of introduction from the research team where the help-seeking doctor could consent to be contacted a year later. The help-seeking doctor would then choose whether to post the letter after the peer support session. The forms were to be handed out throughout 2019. Most of the peer supporters valued the initiative, but several expressed hesitance and said that handing out such a form could breach the confidentiality and jeopardise the haven the peer support service is supposed to offer as consent required the doctors seeking support to disclose their identity.

450 (90 peer supporters x five consent forms each) pre-franked envelopes were distributed to the approximately 90 locally-based peer supporters with a letter containing information about the project and a consent form in case the help-seeking doctor wished to take part in the project. With this mode of recruitment, the research team had no knowledge of potential participants who did not make contact. The peer supporters did not know which of the doctors they had supported and handed the information to chose to contact the research team. There was no exchange of information about the doctor between the research team and the peer supporters.

Out of 450 consent forms handed out, we only received 22 forms returned by post, see table 3. This occurred during 2019. We received more consents in the first couple of months of the year. Primo 2020, recruitment to interviews was slow. I reached out by e-mail and the design of the study was face-to-face interviews. With little luck in recruitment and consent forms running lower (the research design was interview within a year +/- 30 days), I changed from reaching out by e-mail to calling those who had left their phone number on the form. With the arrival of Covid-19 in March 2020, person-to-person meetings were rendered impossible. Surprisingly, this speeded up recruitment to the study: When the doctors were called up and asked to take part in an online interview instead of person-to-person meeting, they were

able to find the time. Both initiatives – phone rather than e-mail, and online meeting instead of face-to-face – likely contributed to recruitment.

We were able to conduct 12 interviews during 2020, the first two interviews at the end of April. Among the ten consent forms that did not result in an interview, 5 were contacted primo 2020. These declined to participate for different reasons. 1 reported poor mental health and postponed the interview before cancelling all together. 1 was not contacted, 3 never responded.

Table 3, demographic data 2020

Characteristics of the selected participants (n = 12)	Participants (n)
Gender	
Male	3
Female	9
Age (average 46 years)	
60 – 75	3
50 – 60	2
40 – 50	2
30 – 40	4
20 – 30	1
Medical specialty	
Family medicine	5
Surgical specialties	1
Laboratory medicine	2
Psychiatry	1
Internal medicine	3
Work experience	
0 - 10 years	4
10 - 20 years	5
20 - 30 years	1
30+ years	2

Data collection

The interviews lasted 1 – 1½ hours. The data were collected through semi-structured interviews, which allowed for some flexibility in the questioning, while still maintaining a consistent structure. All interviews but three were carried out by Ingrid Marie Taxt Horne (IMTH) and Karin Isaksson Rø (KIR) in cooperation, the others by IMTH.

The 25 interviews done in the Villa Sana study took place at locations feasible for both parties: At Villa Sana, at an office at Modum Bads' trauma outpatient clinic in Oslo, at a conference room at Oslo Gardermoen Airport, at conference rooms at hotels, at the

Institute for Studies of the Medical Profession, at a hospital and at the office of a GP. The interviewees were offered tea, coffee, and on some occasions, something to eat. Travel expenses to attend the interview were covered for all parties, two of the participants even flew from across the country to take part in the study.

For the local peer support service, ten of the interviews took place via video link, two of the interviews by phone. The two interviews by phone were carried out by IMTH and the remaining ten by KIR and IMTH.

Before each interview, IMTH and KIR introduced themselves and repeated the information already given in writing about the study, such as aims of the study and that the interviewees were free to withdraw from the study up until publication of data. For the interviews from Villa Sana, written consents to participation were collected at both interviews. For the interviews from the local peer support service, oral consent to participation was requested via video link or phone. A written consent to be contacted was already in place.

At the beginning of the interviews, the doctors were asked to talk a bit about their private situation, their medical background, and their reason for seeking peer support. The interviews were then carried on focusing on collecting in-depth accounts of the doctors' experiences with peer support in an open approach (167). IMTH and KIR strove to create a friendly and open ambience where the interviewees could feel safe enough to talk about their private situation and the reasons they had sought peer support.

Data management

Data were digitally recorded – audio only – and transcribed verbatim by a research assistant. IMTH transcribed one of the first interviews. Anonymised transcripts were then imported into the data software NVivo to facilitate systematisation of coding of data. The original transcripts were stored on an off-line, secured computer at Modum Bad only used for the purpose of this study.

Data analysis

The data were analysed using systematic text condensation, a method for identifying, analysing, and reporting themes within the data. The transcripts were coded both by hand and by using the data software NVivo and analysed for themes and patterns. Data were triangulated. Triangulation refers to a research approach that enhances the reliability and

accuracy of findings. It involves using multiple methods, theories, or researchers in a study to address potential biases that may arise from relying on a single source. Triangulation was done by employing multiple data sources; we conducted two sets of interviews with the same doctors in the Villa Sana study, and we involved multiple researchers. Two researchers were involved in the data collection and four (Papers I and II) and five (Paper III) researchers in the analysis process to increase the reliability of the findings.

Systematic text condensation is a qualitative analytical approach developed by Kirsti Malterud, a Norwegian doctor and researcher. The approach is based on a modified version of Giorgi's psychological phenomenological analysis method (168, 186, 187). Systematic text condensation aims to distil the essence of the empiric material and present it in a clear and concise form. One of the key features of systematic text condensation is its focus on maintaining the integrity of the texts. The approach allows for a nuanced and detailed understanding of the data, while also making it easier for others to understand and interpret. The latter was important to me, as I want the studies to be available to Norwegian doctors without the doctors being required to have detailed knowledge of qualitative research. Systematic text condensation offers a structured, stepwise approach to the analysis of qualitative data, see table 4.

Table 4, Procedures for analysis according to Systematic Text Condensation adapted from Malterud (168, 186)

1. Total impression – from chaos to themes	Reading through the material to get a general impression of the whole. Looking for preliminary themes associated with the research question.
2. Identifying and sorting meaning units – from themes to codes	Identify meaning units, give them a code. A code is a label gathering connected meaning units into groups.
3. Condensation – from code to meaning	The thematic code groups across individual participants constitute an analytical unit for further abstraction by condensation of content.
4. Synthesizing – from condensation to descriptions and concepts	From the condensates, we "develop descriptions and concepts, providing credible stories that can make a difference by elucidating the study question."

The first step in systematic text condensation is to read the entire text, identifying key themes and patterns. In Paper I, such a preliminary theme was the respondent's relationship to sick leave.

From preliminary themes, the researcher identifies meaning units (passages of text) and codes them. This highlights the most important ideas and themes. The thematic code groups are then condensed. Condensation is the process of writing texts that summarise the codes. The texts are written in first person singular voice and constitute refined condensates.

Lastly, these condensates are re-written and synthesised until they are concise, coherent, and representative of the empiric material. They should provide credible stories 'that can make a difference by elucidating the study question' (168, 186, 187). In Paper I, we found that the participants' relationship to being on sick leave themselves could be more decisive when they sought peer support than their level of suffering.

In a parallel process, the interviews were carefully reviewed to identify key quotes that would highlight the analytical points. It was crucial for the labels assigned to the various themes to accurately reflect the content and meaning of the quotes. Throughout this process, the labels were modified multiple times to capture the essence of the statements in the most effective manner. We revisited the codes and entire data sets several times to ensure that the final narratives remained true to the data.

Before submission of all three papers the interviewees have been sent the result sections of the papers, including the quotes for approval.

Analysis driven by theory, Papers II and III

Added to Systematic text condensation, we needed a theoretical perspective to understand and interpret the data for Papers II and III. The theoretical perspectives are presented in Chapter 3. The use of theory in qualitative studies can provide a framework for understanding and can help to guide the research process and ensure that the findings are grounded in existing knowledge. A conceptual framework can help to identify the key variables and relationships that are being studied and thus focus the research (188, 189). When working with Paper II, Schein's model became a lens through which to view and interpret the data. This approach resulted in our going back and forth between data-driven and theory-driven analysis. The theory proved useful in identifying patterns and

connections. This helped to provide a more nuanced and in-depth understanding of the data, and offered insights and perspectives that we may not otherwise have considered. As an example, Schein's perspectives were decisive in discovering that the doctors expressed themselves differently around their own beliefs and values regarding medical professionalism in the second set of interviews (2019) compared to the way they did in the first set of interviews (2018).

These analytical methods have contributed to generate in-depth understanding of doctors' help-seeking behaviour and how peer support can be useful for them.

Literature in the field of physician health

Getting acquainted with the research field 'physician health' and 'peer support' poses some specific challenges as opposed to getting acquainted with, for example, 'E. coli'. As pointed out by Tyssen(76), to identify relevant literature is complicated by an abundance of results that are not relevant, as they refer to the doctor at work as a health care professional and not to the doctors´ own mental distress or needs.

To locate peer support services for doctors internationally, see table 1, I searched by using the search engines 'Google', 'Bing', and 'Google Scholar'. The key words searched for were 'Peer support doctors' + country, 'Peer support doctors' + country, 'Doctors for doctors' + country, 'Kollegastøtte leger', 'Soutien par les pairs pour médecin', 'Soutien par les pairs pour médecin + pays' and so forth. Employing this search mode, no results came up from Asia, Africa, or South America. That is not to say that these continents do not offer peer support to doctors, but it is reasonable to assume that they are few and, if advertised online, they are advertised in a language foreign to the scope of this thesis.

Chapter 5 Presentation of the papers

Paper I

Why do doctors seek peer support? A qualitative interview study.

Ingrid Marie Taxt Horne, Frode Veggeland, Fredrik Bååthe, Karin Isaksson Rø

Aim: To understand how doctors reflect on when and why they seek help from an organised peer support service.

Materials and methods: Data were collected through audiotaped, qualitative, semi-structured interviews. The study was set in a peer support service accessible to all doctors in Norway. Thirteen doctors were interviewed after attending a counselling service in fall 2018. They were selected to represent variation in gender, demographics, and medical specialty. Doctors were excluded if the interview could not be held within 10 days after they had accessed peer support. The interviews were analysed with systematic text condensation.

Results: The doctors' perspectives and experiences of when and why they seek support and their expectations of the help they would receive are presented. Barriers to and facilitators of seeking peer support are discussed. Three categories of help-seeking behaviour were identified: (1) 'Concerned—looking for advice' describing help seeking in a strenuous situation with need for guidance; (2) 'Fear of not coping any longer' describing help seeking when struggling due to unreasonable stress and/or conflict in their lives; and (3) 'Looking for a way back or out' describing help seeking when out of work. Expectations of the help they would receive varied from dialogue and advice to career guidance to treatment. The confidential setting and the no record-keeping policy of the service were thought of as being important in lowering the threshold for help-seeking. Motivations for seeking help had more to do with factors enabling or restricting help-seeking than with the severity of symptoms.

Conclusions: Many different situations lead doctors to seek peer support, and they have various expectations of the service as well as diverse needs, motivations, and constraints in seeking peer support. Further research is warranted to investigate the impact of peer support and how to tailor the service to best suit doctors' specific needs.

Paper II

How distressed physicians act and relate to their challenging situation a year after seeking counselling at a centralised peer support service – a qualitative study.

Ingrid Marie Taxt Horne, Frode Veggeland, Fredrik Bååthe, Karin Isaksson Rø

Aim: Medical culture creates expectations of the doctor's role. Studies have pointed out that there are cultural values that can make it difficult for doctors to voice, accept, and deal with situations threatening health and well-being. This study investigated the influence of peer support service for doctors in distress a year after a counselling visit.

Materials and methods: Twelve doctors, purposefully sampled in relation to demographics and medical specialty, were interviewed shortly after attending peer support service in 2018, and were re-interviewed a year later. The setting was a peer support service accessible to all doctors in Norway. The semi-structured interviews were audiotaped and analysed via systematic text condensation and interpreted within a theoretical framework, including Schein's theory on organisational culture and conceptions of the hidden curriculum in medicine.

Results: Each pair of interviews (one in 2018, and one 12 months later) provided a glimpse into a highly personal story. The material provided great variation regarding both the situation they sought peer support for, and how they had handled the situation a year later. A common theme in the first interviews was the difficulty of accepting the individual situation because of beliefs and values concerning what a good doctor ought to be; strong, healthy, and always put the patient´s needs first. At the one-year follow-up, the interviewees questioned or had changed these beliefs and values, to some making it possible to accept and adjust their situation. Based on these beliefs and values, the authors have constructed taken-for-granted underlying basic assumptions that resonate with the hidden curriculum in medicine and with the empirical material altogether.

Conclusion: Peer support offers an arena for facilitating and legitimising important conversations regarding professional cultural values. By questioning their beliefs and values concerning the doctor role, and then voicing them at the peer support service, it became possible for the doctors to rethink, accept, normalise, and reframe their view of what a good

doctor is. This shift of beliefs and values in the individual professional can contribute to questioning problematic cultural 'truths' generally within the medical profession of what a good doctor ought to be.

Paper III

Understanding peer support: a qualitative interview study of doctors one year after seeking support.

Ingrid Marie Taxt Horne, Frode Veggeland, Fredrik Bååthe, Christina Drewes, Karin Isaksson Rø

Aim: This paper explores how doctors perceive the peer support service and how it can meet their needs.

Background: Doctors´ health is of importance to the quality and development of health care and to doctors themselves. As doctors are hesitant to seek medical treatment, peer support services, with an alleged lower threshold for seeking help, are provided in many countries. Peer support services may be the first place to which doctors turn when they search for support and advice relating to their own health and private or professional well-being.

Materials and methods: Twelve doctors were interviewed a year after attending a peer support service, which is accessible to all doctors in Norway. The qualitative, semi-structured interviews took place by online video meetings or by phone (due to the COVID-19 pandemic) during 2020 and were audiotaped. Analysis was data-driven, and systematic text condensation was used as strategy for qualitative analysis. The empirical material was further interpreted with the use of theories of organisational culture by Edgar Schein.

Results: The doctors sought peer support due to a range of different needs, including both occupational and personal challenges. They attended peer support to engage in dialogue with a fellow doctor outside of the workplace, and some were in search of a combination of dialogue and mental health care. The doctors wanted peer support to have a different quality from that of a regular doctor/patient appointment. The doctors expressed that they needed and got psychological safety and an open conversation in a flexible and informal setting. Some of these qualities are related to the formal structure of the service, whereas others are based on the way the service is practised.

Conclusions: Peer support seems to provide psychological safety through its flexible, informal, and confidential characteristics. The service thus offers doctors in need of support

a valued and suitable space that is clearly distinct from a doctor/patient relationship. The doctors' needs are met to a high degree by the peer-support service, through such conditions that the doctors experience as beneficial.

Chapter 6 Discussion of findings

Doctors 'reluctance to seek healthcare is well recognised in research literature (4, 9, 22, 23, 78, 105, 158, 190-194). Hu et al. find that the most commonly identified source of support for doctors are physician colleagues (31). The institution of peer support services offers doctors an alternative when they need support and is meant to accommodate a lower threshold for help-seeking, often by providing confidentiality and anonymity (112-114, 119, 120, 123, 126, 132, 133, 138, 139). It is important to prioritise the health of doctors, because they report high levels of distress such as burnout, depression, and suicidal thought (11, 18, 86, 87, 89, 94). The situation is demanding for many of them. In 2017, the extended knowledge of physician health resulted in a new inclusion in the Declaration of Geneva – A Modern-Day Doctor's Pledge. The 68th World Medical Association General Assembly added 'I will attend to my own health, well-being, and abilities in order to provide care of the highest standard' (1, 195). It is thus crucial to provide preventive measures and support to help doctors maintain good health and well-being, as this has consequences for both doctors and their patients. In this thesis, we investigated the reasons why doctors seek peer support, their expectations, and the factors that hinder or promote such support-seeking behaviour. We also investigated what circumstances the doctors believed were important for them to benefit from using the services. Understanding these factors can provide insights into how to better support doctors in maintaining good health and well-being, ultimately leading to better patient care.

Why and when do doctors seek peer support? What kind of help do they expect to receive and what factors enable or restrict help-seeking?

This thesis is based on interviews with two sets of participants who had made use of two different peer support services. We found corresponding reasons why the interviewees had sought support in both sets. Based on the empirical material, a broad spectrum of reasons for attending peer support was described. Some doctors expressed concern about their lack of work-home balance, and were looking for advice on how to handle the situation they were in. These doctors were struggling with feelings of incompetence and excessive responsibility at work. Others feared that they would no longer be able to cope due to understaffed workplaces, experiences of adverse patient-related incidents, and/or conflicts at work resulting in distress, such as sleep disturbances, feelings of hopelessness and

exhaustion. Some of the doctors had already been in touch with healthcare, and were on sick leave or out of work at the time they sought support. These doctors looked for guidance on how to return to work or how to manage their situation. A few (younger) doctors expressed regrets about their choice of profession, due to how demanding it is to be a doctor. These sought advice on how to cope and whether they should continue working in the profession. Data from Villa Sana demonstrate a trend of younger female doctors seeking help over the last couple of years (184). This might influence the reasons doctors seek peer support. Rosta et al.'s research demonstrate increased job stress in the period 2010-2019, while Hertzberg et al. found that doctors need to compromise to comply with demands both at home and at work, thus challenging a healthy work-home balance (92, 148, 196). These trends are likely to influence the reasons for seeking peer support. Lack of work-home balance has been pointed to as an important risk factor for burnout among doctors (64, 92, 197).

According to Isaksson Rø et al. (59) and Garelick (30) doctors seeking support struggle with burnout and high levels of distress, which is congruent with our findings. The doctors who sought advice for more easily managed issues recognised their behaviour as 'atypical for doctors', thus they were still attentive towards the hidden curriculum advocating a culture of efficiency and achievement, sickness presenteeism, and stigma of doctors mental distress (24, 53, 198). Giæver et al. describes doctors 'consideration of legitimate versus illegitimate reasons for absence from work. Conditions such as stroke, infections, contagious diseases, and cardiac infarction are described as respectable illness excusing sickness absence. Chronic and mental illness are considered illegitimate conditions for calling in sick , thus attaching stigma to the latter (22). It seems that peer support reaches doctors in need of help. Many of the interviewees in this study sought support after receiving explicit advice from their GP, a doctor friend, or colleague. In the Villa Sana sample in the present study, all but one sought peer support after receiving such a recommendation. Research from 2003 demonstrates that 55% of the doctors who attended Villa Sana came as the result of a recommendation from another doctor (59).

It can be assumed that the reasons doctors seek peer support also is guided by how the specific peer support services market themselves and what kind of services the doctors perceive peer support to be, together with their threshold for seeking help (116). Some

services offer confidential therapy, such as the British DocHealth, a psychotherapeutic consultation service (128). Some of these elements coincide with the Norwegian peer support services who also offer conversation with psychiatrists (or psychologists) in a strict confidential setting. However, DocHealth offers treatment, which is not the case in Norway. Peer support in Norway offers counselling or courses that are preventive, and not defined as treatment. But whether the service is perceived as prevention or treatment can be problematised. Other services offer support specifically to doctors under investigation by a medical counsel (123, 130), or support for doctors struggling with addiction (118, 131). In reference to the latter, Norway has a comparable service aimed specifically at doctors struggling with addiction at the Trasop clinic (118). Yet other services offer well-being programs such as mindfulness training (121) or support groups for doctors in training (134). Finally, in the US, there are services that operate by outreach after an incident with the potential of second victimisation at the hospital (56, 119, 120). Thus, these doctors attend peer support as the result of specific incidents at work. The reasons doctors seek support in this study is in line with findings by Hu et al. who report physical and mental illness, experiences of serious adverse patient events, legal situations, involvement in medical errors, substance abuse, and interpersonal conflicts at work as likely contact reasons to a peer support service (31). However, Hu et al. did not investigate a specific peer support program, instead they queried doctors about plausible reasons for them to attend a peer support service.

The interviewees reported feeling uneasy about raising concerns or discussing their challenges at the workplace. Some said they did not know where else to turn for help, other than the peer support service. These results harmonise with studies by Montgomery et al. describing a non-supportive professional and organisational culture contributing to problematic silence in health care (78, 199). This in turn limits the possibility of doing something about problems in the workplace (if the problems are work-related), and highlights the importance of a low-threshold service outside the workplace.

The doctors sought conversation and, to a lesser extent, concrete advice regarding the problems or difficult situations they were facing. With no pre-selection or referral to the peer support studied, the expectations of the services varied significantly. From both samples, some came for advice and support, some hoped for career guidance, while others

sought medical care, such as referral to therapy or assessment of psychotropic drugs. In the Villa Sana sample, when some of the doctors did not receive the healthcare services they needed, they expressed disappointment that, despite confiding in a colleague with medical expertise, they still had to start all over by booking an appointment with their GP or a therapist to get necessary medical help. Internationally, many of peer support services do offer referrals if needed (110, 123, 125, 138), or offer therapy (128). In the sample from the local peer support service, the motivation for seeking support harmonises with that from Villa Sana. But in the local peer support sample, several of the interviewees had deliberately sought out a psychiatrist peer supporter, and some attended therapy in continuation of peer support. This transition of roles from peer supporter to health care provider was described by some as confusing, but they were all grateful to get the medical attention they needed.

Having a high threshold for seeking help was associated in our study with mental distress. Having a high threshold can be linked to both individual psychological and cultural factors, i.e., those who seek help, as well as to organisational features of the peer support service. There are also connections between these, for instance, a lack of acceptance of being ill in the professional culture making it even more important to have a service that ensures confidentiality. In a qualitative study by George et al., common barriers to seeking healthcare are identified, including fear of consequences and concerns about confidentiality (21). Further, half of the participants in George's study reported the potential stigma associated with mental health problems as preventing them from seeking adequate help (21). Even with strict confidentiality and no record keeping in the Norwegian peer support services, some of the interviewees in this study had waited a long time before they reached out for peer support. To some, strict confidentiality was what made it possible to use the services. Regardless of why they sought support, participants stressed the need to keep the strict confidential setting in order to lower the threshold for colleagues suffering from addictions or severe mental illness.

Unfavourably comparing themselves to colleagues who seemingly managed both work and life postponed help-seeking among participants in this study. Fox et al. refers to unwell doctors as 'challenging the culture of immunity to illness'. In this way he describes the professional culture that fosters reluctance to seek help or treatment to such an extent that doctors can get the impression that they are in fact immune to getting ill (200). But doctors

do become ill. In this study we found that doctors both self-medicated and neglected illness. The perception of doctors ''immunity to illness' may deepen the understanding of research documenting doctors 'tendency to attend work when ill and to self-medicate (21, 22, 24-27, 105, 201).

What types of changes do doctors report a year after receiving peer support?

Approximately one year after participating in peer support, the empirical data indicate a range of benefits attributed to the support provided. Overall, the interviewees reported that they had developed some coping mechanisms for their challenges, and attributed this to feeling validated through the support they received. The interviewees reported that they found the personal and professional recognition they needed through peer support services. This emphasis on recognition aligns with the findings of Lindgren et al. regarding aspects of professional fulfilment in a work setting (202). Lindgren et al. describe the display of interest in one's opinions or suggestions as key to keep doctors' engagement alive, as well as adding to their perception of 'fulfilling the doctor role' (202).

This also corresponds with the observation that doctors sought dialogue and, to a lesser extent, specific input on problem-solving strategies. Getting help to 'name' the problem/situations and finding language to increase their self-understanding were emphasised as valuable. The benefits of accepting the need to make changes in their work situation, take periods of sick leave, or take time away from work were described. The peer support arena was described as being important in processing unfortunate patient incidents. The experience was also said to be used to promote quality over quantity of care upon return to work. Interviewees described the peer support sessions as having helped them to recognise and accept the need to make changes in their relationships with their partners or children. Peer support also served as a catalyst for seeking formal therapy and treatment. Peer support can thus be important in relation to changes in job-related factors, in private situations, and in relation to seeking treatment. Challenging situations in any of these areas are described as drivers of burnout in the literature (27, 85, 86, 92, 197).

According to Isaksson Rø et al., doctors experience reduced levels of burnout, depression and anxiety both one and three years after attending peer support (42, 43). Further, their research affirms a connection between sick leave and reduction in burnout levels in a three-year perspective (66). Dyrbye et al. studied a professional coaching intervention conducted

by phone for doctors over a period of five months (64). Professional coaching is distinct from peer support: the coaches in Dyrbye et al.'s study were not doctors and did not work in health care, however, they did provide conversation and support. The intervention in Dyrbye et al.'s study yielded a 17% decrease in levels of burnout. Further, their study found improvements in reported life quality and resilience (64). However, previous studies have not identified how the doctors made use of their experiences with peer support or coaching. This thesis gives insights into the doctors 'thoughts and actions in the year after attending peer support.

How can peer support facilitate awareness of and promote changes in professional cultural values that can help doctors to self-care?

In the empirical material, we found reported changes in beliefs and values concerning medical professional culture a year after attending peer support. These changes seem to have promoted sustainable change in the doctors' lives, implicating a change in their basic taken-for-granted assumptions. To accept a need for time off work was initially difficult for many of the interviewees. Minimal absence from work and early return to work when ill are generally encouraged to prevent dropout. This attitude is also at the core of the hidden curriculum, dictating a taken-for-granted basic assumption in the medical culture that work always comes first (49-55, 103, 104). However, research documents that sickness presenteeism among doctors is associated with reduced quality of patient care, poorer physical health, decreased job satisfaction, and dropout from work (9, 10, 20, 22, 25-27, 203). According to a qualitative study by George et al., interviewed doctors 'wanted there to be a change in the culture of medicine, such that there is acknowledgement of the importance of taking care of oneself, expectations of some illness during their career, and increased awareness about stigmatised diseases' (21). This is in line with findings by Shanafelt et al. addressing the need to heal the professional medical culture by acknowledging the need for self-care, human limitations, and the cultivation of self-compassion (78).

The interviewees in this study reported that having access to a space where they felt safe enough to discuss their issues allowed them to refocus and reconsider their assumptions concerning what a good doctor ought to be. According to Hertzberg et al., the good doctor is traditionally a dedicated doctor with high work attendance and high work capacity.

Hertzberg further defines high work capacity as 'the willingness to go the extra mile, work overtime and work efficiently', thus advocating the hidden curriculum through sickness presenteeism and putting work first (196). Peer support services facilitated reconsideration through an approach that encouraged contemplation and reflection in a non-judgmental manner, which in turn can lead to a redefinition of the 'good doctor'.

The empirical data revealed that many doctors discussed the concept of psychological safety without explicitly using the term (175, 176, 204). Some interviewees did not feel psychologically safe in their workplace. For example, they lacked a forum to discuss the tension between ideal treatment and clinical reality. After reviewing the initial round of interviews, it became clear that some interviewees had observed negative consequences from speaking out at work, and that some doctors had personal experiences of working in unhealthy, even destructive, environments. Examples included nepotism, such as experiencing that another less-qualified person got a job in public health care through family connections, bullying by co-workers, isolation at work, being banned from taking part in meetings, even being asked by superiors to quit. To some, this was the primary reasons for seeking peer support. Through peer support, it became possible to attend to their own needs and increase self-confidence to raise their voice at work.

The use of Schein's theory of organisational culture and the hidden curriculum highlighted these findings (53, 172). By examining the interview material through the lens of Schein's theory, we were able to identify how participants' espoused beliefs and values about the nature of the medical profession had shifted, and their own role in relation to it, leading to greater acceptance of their own situation. This allowed us to gain new insights into the empirical data.

According to studies conducted by Diderichsen et al. (205, 206), Hertzberg et al. (196), and Fimland et al. (207) there is an emerging attitude amongst younger doctors in Scandinavia regarding work as being more of an eight-to-four job rather than the traditional 'calling' or full-time commitment. Diderichsen et al. find that the medical students reflect work attitudes that challenge the health care system for more adaptive working conditions (206)'. Both Diderichsen and Aasland et al. find that medical students value a balance between work and private life and consider potential work-home interface stress when they choose

their specialty (206, 208). This is in opposition to attitudes conveyed by the hidden curriculum which, according to Mahood '…glorify specialisation, suggesting that the best and brightest become specialists (52)'. The students in Fimland et al.'s study reported that they felt an expectation of unpaid overtime work from older colleagues and anticipated challenges in standing up for a more humane working day when confronted with a professional culture and strongly rooted traditions in the busy workplaces. The younger doctors and medical students thus represent a new understanding of what the idea of the good doctor implies. Perhaps doctors who choose a different approach to work identity become less vulnerable. They may be able to resist pressure from their employers and maintain self-care to a larger extent, to protect their time off duty, and benefit from sick leave when necessary. Our findings indicate that peer support services may provide a safe-zone for doctors to take their own needs more into account, thereby also attending to their patients' needs in a better way.

What do the doctors say about how various elements in the design of the peer support services impact if and how they benefit from it?

The doctors primarily sought a qualitatively different interaction than that of a doctor-patient when they attended peer support. This difference can be attributed to the valued traits of peer supporters, the way the services were organised, and the peer support setting.

All the doctors valued a peer supporter who was friendly, inquiring, and attentive. They sought a safe and supportive atmosphere that encouraged open communication, which is key in establishing psychological safety (172, 175). Being able to achieve this was seen as important in a peer supporter.

The formal structure of both services coincides, as they practice strict confidentiality, a flexibility concerning practical arrangements, and have a no record-keeping policy. Some of the doctors found the latter to be the crucial factor that enabled them to seek the help they needed. The assurance that their conversations would remain confidential and that there would be no documentation of their attendance of the service gave them a sense of security and the freedom to open up about their struggles without fear of negative consequences. Internationally, peer support services for doctors acknowledges the need of strict confidentiality (28, 112-114, 119, 120, 123, 124, 126, 138). In Barcelona, Spain, there is even the possibility of self-admission for doctors with mental disorders to a hospital (PHP) under a

pseudonym (110). However, one common limitation is that the confidentiality can be disregarded if an individual's safety is at risk. This puts the Norwegian services in a unique position, as they do not have any formalised limitations.

Other interviewees had no reservations about the use of medical records but did not consider themselves to be ill, and therefore felt that their reasons for seeking peer support did not belong in a medical record. It seems that the strict confidentiality and no record-keeping policy of both peer support services are beneficial not only to doctors in need of healthcare and attending support, but also that they enable doctors without severe distress to use the services.

In the local peer support service, doctors highly valued being treated as equals when arranging where and when to meet. They appreciated a flexible peer supporter who allowed them to take part in decision-making and to meet outside of working hours. At the Villa Sana peer support service, the doctors booked appointments at their convenience. These findings harmonise with research that emphasises the importance of establishing low-stigma and easily accessible peer support services for doctors (40, 161, 209). The Norwegian services (and research legitimising the services) thus take part in reduction of stigma and increase the accessibility to mental health services for doctors. Together they provide a valuable resource for doctors in need of help.

In recent years, there has been a significant increase in number of doctors seeking help both in the services at Villa Sana and the local peer support service (152). The discussed peer support services are designed specifically for doctors in Norway and paid for by their occupational organisation (117, 181). This might lower the threshold to make use of them. The setting is designed to reduce barriers to seeking help and to encourage attendance. This thesis affirms that the services can meet a variety of both work and privately-related issues. The doctors decided that there was a need for change at the time they sought out the services. In this way, it is an important element of self-selection that means that doctors are prepared to make changes in their lives even before they use the services. However, this does not prevent the services from contributing to reflection, raising awareness of different ways forward, and thus giving direction to the changes.

When studying the empirical material, we noted that some of the issues brought up at the peer support services ideally could have been addressed at the doctors´ place of work. Schein highlights collegial support in the workplace as an important factor in building psychological safety through positive role modelling (172). In a qualitative study looking into learning processes in young doctors, Høifødt et al. recognises peers as potential representatives of a powerful resource in the learning process and suggests 'more critical reflection on and in practice', as well as more attention to feelings in supervision at the work place (210). For some issues brought up in this study, we found indications that it could be the workplace that needs change, not the doctors.

Chapter 7 Methodological considerations

Reflexivity

Reflexivity refers to the process of critically reflecting on the researcher's own assumptions, beliefs, biases, and position, and how these may influence the research process and the interpretation of the findings. Reflexivity is an important consideration because of the subjective nature of the data, and the interpretation of findings can potentially introduce bias and confounding factors. In interviews, the researcher also interacts with those being researched, resulting in an interactive process (164, 166-168, 211).

When I began with this project, I had a background as a psychiatrist, but I had not worked as a peer supporter. The first year, I worked 50/50 as a peer supporter and researcher. To gain an understanding of peer support, I also attended counselling given by the other peer supporters who worked at Villa Sana. The insider perspective of the service was considered to be of value to the study. Thus, I am to some degree invested in positively portraying peer support for doctors, and I did believe it to be beneficial before I started interviewing. However, I held a watchful posture, bringing with me experience from the field of psychiatry that short psychotherapeutic interventions have their limitations. Even though peer support for doctors is a preventive measure, counselling involves similarities with a therapeutic setting. Further, in a meeting between two people, personal chemistry plays an important role.

According to Berger, there are advantages in researching the familiar: 'easier entrée, a head start in knowing about the topic and understanding nuanced reactions of participants' (211). My position as a doctor working at the peer support service Villa Sana was crucial in gaining access to the interviewees. It also probably influenced the information the interviewees were willing to share through the facilitation of trust in relation to the interviewees, which presumably lead to more richness in the material. The ability to carry out research that required participants to trust that the confidentiality and anonymity were safeguarded was also strengthened by the peer support services' good reputations. Studying an area in which I am knowledgeable as a fellow doctor was an advantage when posing relevant follow-up questions. And as pointed out by Berger (211), I understood the language and expressions specific to the profession. According to Brinkmann and Kvale (167), having knowledge in the subject matter being researched is important in ensuring quality in study outcomes.

On the other hand, the insider perspective may preclude information gathering and the deepening of understanding by assumed tacit knowledge and, hence, a lack of relevant follow-up questions. Due to our shared backgrounds, the interviewees and I may have taken a shared understanding for granted. The vulnerable narratives told by the interviewees and the establishment of closeness and empathy in the interview setting may have led to less critical questioning. As someone who has shared similar experiences with the interviewees, I do possess a nuanced understanding of their challenges, which also may have resulted in less rigorous questioning. However, the insider perspective may allow for identification of themes and topics that an outsider researcher might have overlooked. On the other hand, an outside researcher could possibly identify topics and questions that we (interviewers and interviewees, all doctors) did not recognise.

Several strategies for maintaining reflexivity were used in this study: Repeated interviews with the same participants (Paper II), taking notes shortly after each interview, where I included thoughts and reactions to self-reflect, triangulation by involvement of several researchers with diverse backgrounds, the use of different data sources (Villa Sana and the local peer support service), and thorough peer review of papers before publishing (211). All interviews but three were conducted with a co-interviewer, main-supervisor Karin Isaksson Rø (KIR). She is a specialist in occupational medicine, a peer supporter, and has extensive knowledge of qualitative interviewing. Even though she is also a doctor, this may have reduced the potential for insider effects through her contributions during interviews and subsequent discussions.

Credibility and trustworthiness of the study were increased by multiple researchers taking part in the analysis process and the writing of the papers. I worked with two co-supervisors: Frode Veggeland (FV), who has a background in political science; and Fredrik Bååthe (FB), who has a background in health management. Both took part in this study from the very beginning. Their roles as external researchers with different academic backgrounds and without interest in a specific study outcome have been extremely valuable in attaining reflexivity. Through discussions of interpretations and analysis, critical feedback, and introduction of theory they have added credibility and value to the study. Co-author Christina Drewes (CD), who has a background as an anaesthesiologist and researcher, also doubled as a user representative and peer supporter, and took part in analysing and writing

Paper III. Her knowledge and expertise in experiencing several areas added valuable quality to the study. Together, the research group provided multiple perspectives and reduced the potential for bias.

Internal validity

According to Kvale and Brinkmann, internal validity refers to the extent to which the research conducted examines what it set out to do (167). There are different approaches that can be used to increase validity in qualitative research: triangulation through self-reflection, involvement of multiple researchers, and gathering information from different sources are some of these (211). By interviewing 12 of the doctors twice, we increased validity and reliability. The second interview was conducted as longitudinal qualitative interviewing (LQI), not as member checking, but by comparing the two sets of interviews we reduced the likelihood of chance findings. We interviewed two sets of participants who had used two different sources of peer support. Results from the studies converged on several findings, as well as with existing literature, such as why doctors seek support and the experienced psychological safety at the peer support services. This further strengthens the reliability of the study. It is, however, uncertain whether the responses of other participants would generate different results. According to Widerberg, basing formation of knowledge on empirical data implies a logic paradox of uncertainty: the more information you gather, the greater the variety and complexity tends to be (165).

A more comprehensive and in-depth understanding of the research topic was achieved by the introduction of theoretical perspectives, thus strengthening internal and external validity. Internal validity was strengthened by the introduction of additional access into methods: analysis driven by theory, described in detail in Chapter 4. The theoretical perspectives allowed us to explore different aspects and gain a more nuanced understanding of peer support. External validity was strengthened by a demonstration of how the results fit within existing knowledge. This can make the research more applicable and relevant, for example by understanding the hidden curriculum as a tool for recognising the need to modify medical professional culture to help doctors prioritise their own well-being. According to Laksov's work, by using a known theoretical lens that has already been introduced to the research field, we further enhance this mechanism to 'help the field build

up a coherent body of work, which is transferable beyond the conditions in which individual studies were conducted' (188). This thesis thus contributes to existing knowledge through the incorporation of established theories in the field of physician health.

Lost in translation

A potential limitation is the language barrier. All the interviews were conducted in Norwegian. The citations were carefully selected and translated to English by the main-supervisor (KIR) and me, in cooperation. Finally, they were subject to professional language editing before the papers were submitted. As English is a second language for the whole research group, we do not know what might have been lost in translation.

Memory and recall bias

In all three sets of interviews, the interviewees may have been prone to recall bias. Recall bias can be defined as inaccurate recall of information (212). There are a number of circumstances that might have 'coloured' the memory of receiving peer support: for Papers II and III, a year (+/- 30 days) had passed since the participants attended peer support, and some participants in Paper III had attended therapy in continuation of support. Additionally, interviews in general usually provide more socially desirable response-giving (underreporting of embarrassing, troublesome episodes) (213). To mitigate recall bias and trigger memory, we used several of the techniques summarised by Brinkmann and Kvale during the interviews, such as giving the interviewee time to remember, provide concrete clues, use timelines, and ask the informant to give a free and detailed description of a specific memory (167). These techniques increase validity and may help the interviewee to give recounts that are 'close to the lived experiences of phenomena in the lifeworld' (167).

External validity

External validity refers to the extent to which the findings of a study can be generalised to other populations, settings, or contexts. This study is set in a Norwegian context. The data sets involved small and non-random samples (166). However, we opted for high information power in recruitment, as suggested by Malterud et al. (182). According to Malterud, 'Information power indicates that the more information the sample holds, relevant for the actual study, the lower amount of participants is needed' (182). The inclusion of 25 eligible doctors from across the country with variety in age, sex, medical specialty, and years of

medical practice indicates an adequate sample size to generate informative data. They had all attended peer support for doctors within the timeframe given, according to the study design. The interviewees came across as genuine and truthful, adding credibility to the study.

A limitation of qualitative research is the difficulty in generalising the findings to a larger population. It is therefore not possible to draw definitive conclusions or generalise about 'all doctors working in Norway' from this data. However, qualitative research offers valuable insights and perspectives that are otherwise not accessible. Using rigorous and transparent methods allows other researchers and reviewers to evaluate the quality and trustworthiness of the research.

As discussed in Chapter 1, peer support services for doctors are widespread throughout the Western world. Although healthcare systems may be structured in different ways, many aspects of being a doctor, including a congruent professional culture, share similarities. This thesis therefore has an external validity that can add useful information and understanding to medical associations, peer support services and health managements, even in contexts outside Norway.

Chapter 8 Ethical considerations

The design of this study divided data gathering into three phases: 1. Doctors were interviewed within ten days after they attended Villa Sana; 2. The very same contributors were re-interviewed approximately a year later; and 3. Doctors who had attended the local peer support service Støttekollegaordningen were interviewed once, a year after they attended the service.

This design was established through discussion between the peer counsellors at Villa Sana and the researchers. From a scientific point of view, it would have been useful to perform the interviews before the doctors had received any counselling to get the unfettered story of their prior knowledge of peer support, motivation, expectations, and perceived thresholds when reaching out. This approach raised several ethical considerations, the major one being a fear that participation in the study before counselling might disturb the natural rhythm of the counselling day. Doctors reach out to the peer support service at a vulnerable time in their lives. At the beginning of a counselling session, pressure is quite often released when doctors verbalise their mental strain. It was considered unethical to disturb this rhythm by questioning why they wanted to attend peer support in a research setting without being able to provide the professional caregiving and counselling needed, which might result in their feeling pressured to participate in the study to receive peer support (which is free of charge). The peer supporter might be influenced by knowing whether the doctor participated in the study and approach the counselling in a different way (the service is influenced).

Gathering the data ten days after received counselling also poses ethical considerations. The participants might have felt an expectation to compensate for using the service: The doctors can have felt an obligation to 'pay' for the counselling with participation in the research.

Some of the same ethical considerations applied to the participants from the local peer support service as well, that they might have felt obligations to 'pay' for the participation in the research after receiving peer support. This would have been mitigated by the fact that they chose freely whether to engage in the research after they had left the peer supporter, and also because they had not met any of the researchers, which was the case for several participants from Villa Sana where I gave lectures at the courses for peer supporter. They

were contacted a year after they gave their consent, which probably made it easier to decline or not respond if they did not want to participate.

To examine if the participants were attended to in an ethically sound and professional matter, questions from Miles and Huberman's (214) research ethics are useful to ask: 'Are the research subjects fully informed about the purpose of the envisaged study? Have they given their free and informed consent? Have they been informed about their right to withdraw from the study at any time?' (214). Participants in the study were informed about anonymity, data storage, and the purpose of the study by a written form prior to the interview. To minimise the aforementioned ethical dilemmas, the form also clearly stated that participation in the research project was voluntary and detached from the services offered by peer support. The participants could choose to withdraw from the study at any time and, if so, their data would have been deleted up to the point of final analysis and publication of results.

Another ethical dilemma arising from the design of the study is time spent by the participants and lack of reimbursement. The researchers are paid, and we get something out of the study: papers published, a thesis, and possible future benefit from the study. The participants, however, had to take time of their busy schedules and were not compensated. Each interview lasted 1–1.5 h, and some of the participants travelled to a suitable place where the interview could take place. Several participants flew from their hometown to Gardermoen Airport to take part in the study. Travel expenses were reimbursed, but they were not compensated for the time spent, or for time taken off work. As a token of gratitude, participants were given a box of chocolates, tickets to the cinema, or flower seeds. This asymmetric relationship was discussed with the interviewees at the time of the interviews, the participants voiced that they found it meaningful to take part in the study, as they considered peer support services to be valuable to the profession. To increase internal validation and ensure the interviewees' participation in the final product, the results section and approval of quotes were distributed to all the participants before submission. The publishing of the results is not a reimbursement per se, but provides participants the opportunity to recognise what they have contributed to creating.

This study represents a particular social context where researchers gained access through already being trusted members of the professional group. The interviews had the potential to evoke difficult emotions, as we asked in detail about why the doctors had sought peer support. In this setting, and specifically because the two researchers who carried out the interviews are both peer supporters (and I am also a psychiatrist), the role of the researcher carried with it a risk of misinterpretation. Participants in the study may have perceived the interview setting as being counselling, even though this was not implied. To mitigate this, participants were informed that they could contact us if they needed support after the interview. However, none of the participant made use of this offer.

The studies were approved by REC (Regional Committees for Medical and Health Research Ethics) South East.

Chapter 9 Conclusion and implications

This thesis comprises three studies exploring different aspects of peer support for doctors. Doctors report a broad spectrum of reasons for seeking support, ranging from having concerns and seeking advice, feeling unable to cope any longer, to having been on sick leave and now looking for a way either back to work or a way out. The fact that the services accommodate such a variety of problems and challenges among doctors may be attributed to the flexible characteristic of the services, as well as the fact that the services offer a safe and confidential space for dialogue.

Peer support creates a safe setting in which the doctors have time for reflection. Reflection seems to fall into two main categories. For some, reflection help them to see new opportunities regarding how to handle difficult situations, and they may see more alternative ways of acting than before. For others, reflection may additionally lead them to question their own role as doctors and the professional culture they take part in.

A year after peer support, the doctors seem to have a greater acceptance of their own mental and physical issues, and there seems to have been a shift related to some aspects of how they think about their professional culture. Such reconsideration can enable doctors to initiate changes both at the workplace and in their private lives that help them to better see and attend to their own needs. The interviewees attribute the facilitation of these changes to both personal characteristics of the peer supporters and the flexible, safe, and confidential nature of the peer service.

Peer support services are instituted as preventive measures. As described, some doctors come with concerns and seek advice preventively, in order not to become too stressed or develop burnout. As the present study shows, however, many of the doctors seeking help are already affected by severe mental strain, and some have been on sick leave for some time, making it difficult to label the help as preventive. Thus, the service also seems to work reactively, as a service that is of also use to doctors who have already found themselves dealing with severe problems, in some cases experiencing real crises. However, the described changes can also be regarded as being very important preventive measures: With more acceptance for one´s own limits, reactions, and needs, it could be easier to think preventively in future situations.

This study also finds that medical professionality and the doctor role, especially related to enabling self-care, needs to be addressed among doctors to improve their well-being. Peer support services can promote reflection through providing a 'safe zone'. Several of the doctors in this study express that this type of 'safe zone' does not exist in the workplace.

The results in this study underpin the theoretical perspectives presented. They demonstrate that values and underlying basic assumptions in the medical culture, as described in the hidden curriculum, seem to hinder self-care. They also show that providing a psychologically safe space can enable both altered avenues of action and reflections around and questioning of basic assumptions. This may lead to alternative measures for dealing with one's own problems, as well as an adjusted understanding of professionality that can also include acceptance of one´s own needs and finding ways of addressing them.

Practical implications

The participants in this study describe the peer support services practised in Norway as being useful for a wide range of reasons. It can be an important measure in fighting burnout, depression, and sickness presenteeism. It thus seems important to maintain these existing peer support services in their current form.

The Norwegian services give help to doctors with a wide range of contact reasons by applying the described informal, flexible, and confidential features. This knowledge can be helpful to other peer support services that practice with restrictions on, for example, confidentiality, likely increasing the threshold for help-seeking.

The doctors describe the importance of acquiring an awareness of their own values and taken-for-granted assumptions in terms of being able to accept their own situations and challenges, and enabling instituting measures for self-care. These insights should be spread to the wider medical community so that a collective process of questioning these values and assumptions can be initiated. This can then lead to an increased understanding of the necessity of providing psychologically safe spaces that can contribute to more general preventive measures to enhancing self-care. This can be of benefit for doctors and, subsequently, patient treatment and health care organisations.

Prospects for further research

The findings in this study have shown that several doctors highlight the lack of psychological safety in the workplace. There is a need to conduct research on whether the lack of psychological safety is a problem where doctors work, and why. Providing information to and encouraging the involvement of politicians, health managers, and health care providers is important in such research.

Among the participants, there is also an expressed need for the possibility of a smooth transition from peer support to formal treatment. Practical suggestions to facilitate such transitions should be researched.

It would be important to use the concepts and theoretical understandings from these studies to examine the usefulness of peer support services in other countries. Concepts of medical professionality seem to be relatively consistent across geographic diversity, and studying these phenomena in other countries could give us a more nuanced understanding.

There is a general need for research on peer support for doctors. This is the first study involving doctors who have sought out the local peer support service, Støttekollegaordningen. The qualitative insights gained in this study would be interesting to match with more quantitative data from this group.

We plan to investigate these phenomena in other professions: in nursing and in child protection and child welfare. These professions have a similar type of offer available at Villa Sana, with courses and professional counselling.

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Appendices

Approval to conduct the study [in Norwegian]
Interview guide 2018
Interview guide 2019
Interview guide 2020

Paper I
Paper II
Paper III

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Claus Henning Thorsen	22845515	13.03.2018	2018/199 REK sør-øst C
			Deres dato:	**Deres referanse:**
			09.01.2018	

Vår referanse må oppgis ved alle henvendelser

Karin Isaksson Rø
Legeforskningsinstituttet (LEFO)

2018/199 Bra for legen - bra for pasienten.

Forskningsansvarlig: Legeforskningsinstituttet (LEFO)
Prosjektleder: Karin Isaksson Rø

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst C) i møtet 15.02.2018. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10.

Prosjektleders prosjektbeskrivelse
Leger oppsøker i liten grad hjelp eller behandling og har høyt sykenærvær. Derfor trengs det forebyggende lavterskeltilbud som er lett tilgjengelige. I denne studien vil vi derfor undersøke om og hvordan leger nyttiggjør seg slike tilbud. Vi vil studere utløsende årsaker for å søke hjelp både relatert til arbeids- og privat situasjon, kartlegge graden av belastning og bruk av mestringsstrategier. Studien vil øke kunnskapen om aktuelle utfordringer i legerollen, og om hvordan et forebyggende tilbud kan bidra til å håndtere slike utfordringer Dette vil vi undersøke ved å følge leger som oppsøker slike tilbud med spørreskjemaer over en tre-årsperiode og sammenligne disse med en matchet kontrollgruppe (kvantitativ studie). Vi vil også intervjue et utvalg av disse legene for å forstå på hvilken måte de nyttiggjør seg tilbudet (kvalitativ studie).

Vurdering
Leger har høyt sykefravær, men nyttiggjør seg sjeldent av lavterskeltilbud. I dette prosjektet skal man undersøke årsaker til at leger søker hjelp, ved å undersøke hvorfor leger oppsøker Støttekollegaordningen.

Dette er å anse som en intervensjonsstudie, med kontrollgruppe, hvor formålet er å undersøke effekten av en slik ordning for leger. Man vil kartlegge årsaker til hvorfor noen leger oppsøker denne tjenesten, for derved å få bedre innsikt i hvorledes man skal bidra til økt bruk av denne type forebyggende tjenester.

Leger skal svare på spørreskjema, og de skal følges over tre-år og sammenlignes med en matchende kontrollgruppe. Det vil også bli gjennomført kvalitative intervjuer av et mindre utvalg leger.

I studiens kvantitative del vil man inkludere 250 deltakere og en tilsvarende matchet kontrollgruppe (trukket fra legeregisteret). Utvalget i den kvalitative delen vil være 30-35 personer, litt avhengig av metning. Forskningsdeltakerne rekrutteres gjennom Ressurssenter Villa Sana.

Komiteen mener dette er et godt beskrevet og nyttig prosjekt.

Vedtak
Prosjektet godkjennes, jf. helseforskningslovens §§ 9 og 33.

Tillatelsen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen, og de bestemmelser som følger av helseforskningsloven med forskrifter.
Tillatelsen gjelder til 31.12.2021. Av dokumentasjons- og oppfølgingshensyn skal opplysningene likevel bevares inntil 31.12.2026. Opplysningene skal lagres avidentifisert, dvs. atskilt i en nøkkel-og en opplysningsfil. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato.

Komiteens avgjørelse var enstemmig.

Klageadgang
Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, tredje ledd og forvaltningsloven § 28. En eventuell klage sendes til REK sør-øst C. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK sør-øst på eget skjema senest 30.06.2022, jf. hfl. § 12. Prosjektleder skal sende søknad om prosjektendring til REK sør-øst dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Med vennlig hilsen

Britt Ingjerd Nesheim
Prof.dr.med,
Leder REK sør-øst C

Claus Henning Thorsen
Rådgiver

Interview guide 2018

Reasoning for contacting Villa Sana, 2018

Can you tell us a bit about yourself and your situation (age, work experience, marital status, your health, children…)

Individual level

- *Can you describe the situation that led to your now contacting the Resource Centre Villa Sana for a course or a one-day counselling session?*
- *What are you experiencing in this situation?*
- *What do you find most challenging?*
- *Can you tell us about the main areas that are especially challenging in your situation?*
- *What did you want help with?*
- *What did you want to get out of the counselling session/the course?*
    - *Which expectations did you have in relation to the counselling/course at the Resource Centre Villa Sana?*
- *Are there any aspects that you find challenging about the "doctor role"? If so, which?*
    - *Are they related to work hours?*
    - *Are they related to the work environment?*
    - *Are they related to the burden of responsibility?*
- *Sick leave? If you´ve been/are on sick leave now: What do you think about sick leave in the present situation?*

Institutional level

- *Is it important that the service maintains confidentiality?*
- *Has contact with the Resource Centre Villa Sana made a difference for you?*
    - *What has been of importance?*

    - *Which role does the Resource Centre Villa Sana play in that (possible) importance?*
    - *Which role do other factors play/have?*
- *Which experiences have been useful for you from contact with the Resource Centre Villa Sana?*
- *What was most important for you in your encounter with the Resource Centre Villa Sana?*
- *What were strengths and weaknesses in the contact with the Resource Centre Villa Sana?*
- *Is there anything that could have been better?*
    - *What can/should be changed?*

- Are there any questions you had waited to be asked about/wished to be asked about here today that we haven't posed to you?

Interview guide 2019

Reasoning for contacting Villa Sana, 2019

What has happened since the last time we met?

- *Individual follow-up questions*

What do you now think prompted you to contact Villa Sana last year?

- *What did you want to/hope to achieve by attending Villa Sana?*
- *Why did you think the peer support service was the right place to turn to last year?*

Threshold:

- *What threshold did you experience when you applied to the service?*
- *How low do you think the threshold for applying to Villa Sana should be?*

The way out

Individual level

- *Has contact with the Resource Centre Villa Sana made a difference to you?*
- *What has been of importance?*
- *What role does the Resource Centre Villa Sana play in that (possible) importance?*
- *What role do other factors play/have?*
- *Which experiences have been most useful for you from your contact with the Resource Centre Villa Sana?*

The process of change

Do you attribute any changes in your life to the counselling day/course at Villa Sana?

- *Would you possibly describe your situation differently now?*
- *Are there any important changes in your situation or the way you think about your situation after your conversation/stay at Villa Sana?*
- *Do you think differently now about your work or private situation?*
- *Do you think differently about yourself?*
- *Have you taken action in your life following the contact?*
- *Have you made practical changes in your work or private situation?*
- *Have you consulted health services because of the peer support?*
- *Sick leave? If you´ve been/are on sick leave now: What do you think about sick leave in the time that has passed since you sought help at Villa Sana?*

  What coping strategies have you used? (physical activity, medication, alcohol use, ways of thinking….)

Do you think differently about sick leave now? About therapy?

- *If you attended a course: Have you been in touch with anyone in the group after the course?*
- *Which experiences have been useful for you from your contact with the Resource Centre Villa Sana?*
- *What was most important for you in your encounter with the Resource Centre Villa Sana?*
- *To what extent have your expectations of the Villa Sana Resource Centre been met?*

Institutional level

- *What were the strengths and weaknesses of your experience with the Resource Centre Villa Sana?*
- *Is there anything that could have been better?*
- *What can/should be changed?*

What do you think about the future?

- Are there any questions you had anticipated being asked about/wished to be asked about here today that we haven't posed to you?

Interview guide 2020

Reasoning about contacting peer support in 2019, interviews carried out one year later, in 2020

Intro:

Can you tell us a bit about yourself and your situation (age, work experience, marital status, your health, children…)

Questions:

Individual level

- Where did you first hear about the peer support service?

- Why did you choose to seek out a peer supporter and not another service (GP etc.)?

- Was there something about deciding to contact a peer support that was redeeming in and of itself?

- Why did you contact this particular peer?

- *Would it be okay to be referred to another peer supporter who has a lighter workload?*
- *How important is geographical proximity to the peer? Gender?*

- What situation made you seek advice from a peer?

- *Can you tell us about the main areas that were/are particularly challenging in your situation?*

- What did you want to get out of the counselling?

- What was it about the counselling that was meaningful to you?

- How would you describe your situation now?

- *What changes are important in your situation now, compared to before contact with the peer support service?*

- *What steps have you taken in your life after the contact?*
- *Have you made practical changes in your work or personal situation?*
- *Do you now think differently about your work or personal situation?*

- Have you visited the healthcare system as a result of your contact? (Sick leave?)

- What coping strategies have you used? (Physical activity, ways of thinking, alcohol drugs…)

Institutional level

- *Is it important that the service maintains confidentiality?*
- *Has contact with the peer support service made a difference for you?*
  - *What has been of importance?*
  - *What role does the peer support service play in that (possible) importance?*
  - *What role do other factors play/have?*
- *Which experiences have been useful for you from your contact with the peer support?*
- *What was most important for you in your encounter with peer support?*
- *What were the strengths and weaknesses in your contact with peer support?*
- *Is there anything that could have been better?*
  - *What can/should be changed?*

- Are there any questions you had anticipated being asked about/wished to be asked about here today that we haven't posed to you?

ORIGINAL PAPERS

Paper I

BMJ Open

Why do doctors seek peer support? A qualitative interview study

Ingrid Marie Taxt Horne ,[1] Frode Veggeland,[2] Fredrik Bååthe,[3,4] Karin Isaksson Rø[4]

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ABSTRACT

Objectives To understand how doctors reflect on when and why they seek help from an organised peer-support service.

Design Data were collected through audiotaped, qualitative, semi-structured interviews. The interviews were analysed with systematic text condensation.

Setting A peer-support service accessible to all doctors in Norway.

Participants Thirteen doctors were interviewed after attending a counselling service in fall 2018. They were selected to represent variation in gender, demographics, and medical specialty. Doctors were excluded if the interview could not be held within 10 days after they had accessed peer support.

Results The doctors' perspectives and experiences of when and why they seek support and their expectations of the help they would receive are presented, and barriers to and facilitators of seeking support are discussed. Three categories of help-seeking behaviour were identified: (1) 'Concerned—looking for advice' describing help seeking in a strenuous situation with need for guidance; (2) 'Fear of not coping any longer' describing help seeking when struggling due to unreasonable stress and/or conflict in their lives; and (3) 'Looking for a way back or out' describing help seeking when out of work. Expectations to the help they would receive varied widely. Motivations for seeking help had more to do with factors enabling or restricting help-seeking than with the severity of symptoms.

Conclusions Many different situations lead doctors to seek peer support, and they have various expectations of the service as well as diverse needs, motivations and constraints to seeking peer support. Further research is warranted to investigate the impact of peer support and how to tailor the service to best suit doctors' specific needs.

Strengths and limitations of this study

- ► This study provides new knowledge of how doctors reflect on seeking help at a peer-support service.
- ► In-depth qualitative interviews contributed rich material giving insights into doctors' subjective experiences and help-seeking practices.
- ► Through a selection of eligible doctors based on gender, age, specialty and demographics, a wide range of help-seeking behaviours emerged. There is a risk of bias through under-representation of those who declined to be interviewed, potentially because they were too exhausted to participate or reluctant to share private information. To counteract bias, analyses and generation of codes were carried out within an interdisciplinary team.
- ► Although this study was conducted in Norway, we suggest that the knowledge generated about categories of support-seeking behaviour can be of value to organisations providing counselling services for doctors as well as to employers in healthcare, doctors' associations and the community of doctors.

INTRODUCTION

There is a growing awareness that reduced wellness among doctors negatively influences patient care.[1–4] Studies have shown greater reluctance among doctors to seek medical care and psychological support compared with other professionals.[5 6] To facilitate help seeking, peer-support schemes have been instituted in several countries.[7–11] To ensure the usefulness of peer-support services, it is crucial to understand when and why doctors seek peer support and to know more about the factors that enable and restrict them from seeking help.

According to the 2017 Revised Declaration of Geneva: A Modern-Day Physician's Pledge, doctors are obliged to care for their health: 'I will attend to my own health, well-being and abilities in order to provide care of the highest standard.'[12] Nevertheless, there is a persistent gap between doctors' knowledge of diagnoses and necessary treatment and their willingness to seek professional healthcare for themselves when required.[13–15] This reluctance is multifaceted.[5] The traditional image of doctors as self-sufficient, capable and altruistic[16] contributes to them working tirelessly and to a culture of self-treatment. However, in recent years, there has been an increasing awareness of the necessity for doctors to be able to enjoy work–life balance[13 17–19] and promote self-care.[20–22] Changing attitudes toward doctors' needs might challenge the very idea of what a doctor should be even among doctors themselves.[13] According to

recent Scandinavian studies, there is growing concern among medical students and junior doctors about doctors' demanding work conditions and lack of work–life balance, limiting the possibilities for self-care.[16 23]

Efforts are increasing to define the best management to help doctors cope with distress. As doctors are generally reluctant to seek healthcare, specific programmes have been instituted to prevent stress and mental illness in this population. For several years, readily accessible peer-support programmes have been provided in the USA, England, Denmark and Norway.[8 24–26] One might expect doctors' threshold for pursuing these services to have lowered over the years, but the traditional endorsement of a doctor as self-sufficient, in control, and accomplished remains intact.[16] Seeking help exposes vulnerability.

A few studies have examined the reasons why doctors seek peer support.[10 27] However, most of the research has been quantitative and focused on changes in symptom burden. Little is known about the beliefs and reflections of those who seek peer support. Interviewing doctors who have sought guidance from a peer-support service in Norway allowed for exploring these issues.

AIM

The aim of this study was to understand how doctors reflect on why and when they seek peer support, the kind of help they expect to receive and the factors that enable or restrict seeking this service.

METHODS

This study was explorative and interpretative.[28] Qualitative modes of inquiry were employed to understand doctors' reflections on why and in which context they seek peer support and the factors that enable or restrict help-seeking.

The peer-support service

Villa Sana is a short-term counselling programme for doctors established by the Norwegian Medical Association (NMA). The aims are to enhance health and life quality, strengthen professional identity and prevent burnout. Two kinds of interventions are offered. One intervention is a single-day counselling session (6 hours) with a trained mental health professional, where the doctor's life situation and steps needed to handle it are discussed. This can include advice on seeking formal medical treatment including psychotherapy. The other type of intervention is a group-based, week-long course for 8–10 doctors that includes boarding, daily lectures, discussion and physical activity and an individual counselling session. Themes of the lectures are possibilities and restraints in working life, the individual's resources and personality, identity, communication, team work and prevention of burnout. The interventions are easily accessible (no referral needed and short waiting time). NMA covers all expenses, which enables doctors from all parts of Norway to attend. Since the programme is defined as a preventive and not a clinical intervention, no medical records are kept, which ensures anonymity.[10 29] The service is publicised on the homepage of the NMA[30] and in the NMA journal.

If concerns arise regarding a help-seeking doctor's ability to treat patients or if ongoing suicidal plans are revealed, the counsellors, in cooperation with the doctor, initiate contact with a general practitioner (GP) and/or mental healthcare provider.

Participants and sampling

Qualitative in-depth interviews were conducted with doctors who sought a peer-support service in Norway, from August to December 2018.[10] It appeared that saturation was being reached after about 10 interviews, and 13 interviews were conducted in total. This generated a rich dataset to analyse. Interviews were conducted by the first and last author, both medical doctors who have practiced as peer counsellors.

As doctors reach out for peer support at a vulnerable time in their lives it was important that they first received counselling, and that the research interview was subsequent to this. A voluntary, written consent was obtained from participants who were either recruited before the counselling by a mail request or by a direct request when they attended the counselling. As this is a highly confidential service, no record was made of those doctors who attended peer support but did not consent to take part in the study. 'Typical case sampling,'[28] drawn from demographic data, was applied. As the objective was to provide a wide distribution of characteristics of doctors seeking peer support, the sample is illustrative, not definitive.[28] Thirteen doctors (nine females; four males) were selected for interviews. Gender distribution (70% female, 30% male) and distribution between hospital specialties (68%) and general practice (38%) was approximately the same as among the 288 help-seeking doctors at the peer-support service in 2018. Participants came from different parts of the country and the age distribution was 25–70 years (average age: 42 years; see table 1). As the intention was to capture the situation when seeking peer support, candidates were excluded when it was not possible to conduct the interview within 10 days after they had obtained peer support.

Table 1 Participants' (n=13) background information

Gender	Male	4
	Female	9
Medical specialty	Family medicine	4
	Surgical specialties (gynaecology, otolaryngology)	3
	Laboratory medicine (biochemistry, radiology)	2
	Psychiatry	1
	Internal medicine (geriatrics, paediatrics, internal medicine)	3

Patient and public involvement

Patients were not involved in the design or planning of the study. A user—a doctor who had sought support from the peer counselling service—was involved in planning the study, writing the project description, and revising the present paper.

Data collection and processing

The semistructured interviews (1–1.5 hours) explored reasons why participants sought help, how they perceived peer counselling and impacts the counselling had on them. Please see online supplemental files for interview guide. The first author conducted all 13 interviews and the last author coconducted 9 of them, and they took place in locations feasible for all parties. Interviews were audiotaped and subsequently transcribed verbatim by a research assistant. Each interview was given a number and uploaded to a secure database; the identification code was stored separately. The interview data were complemented by observational field notes.

Data analysis

The interviews were analysed using Malterud's systematic text condensation.[31] Descriptive and explorative analysis of the material followed four basic steps: (1) reading through the material to achieve an overall impression, from chaos to themes; (2) identifying and sorting meaning units, from themes to codes; (3) condensation, from codes to meanings; and (4) synthesising, from condensation to descriptions and concepts.[31] The first and last author analysed the first few interviews in parallel and discussed the themes and codes together with the other coauthors until reaching a consensus. The first author analysed the remaining interviews independently. All the authors discussed data generation and concept development, resulting in the emergence of three categories of help-seeking behaviour. The interview texts were then reanalysed to produce rich portrayals of these three categories. The categories were assessed to determine whether they were sufficiently supported by data and then were revised again. The descriptions defining each category were then condensed, and they are presented with illustrating citations.

RESULTS

A wide spectrum of circumstances concerning doctors' help-seeking behaviour was analysed. The perspectives and experiences of when and why doctors seek support are presented in three categories constructed from the empirical material: (1) 'Concerned—looking for advice,' (2) 'Fear of not coping any longer,' and (3) 'Looking for a way back or out.' Rich descriptions of the categories follow. Further, the doctors' expectations of the help they would receive and the barriers to and facilitators of seeking support are presented.

Doctors' perspective and experiences of when and why they seek support

Concerned—looking for advice

In this category, doctors described obligations to perform both at work and at home, resulting in worries and lack of sleep. A feeling of uneasiness linked to the responsibility of being a doctor, such as fear of making mistakes, feeling incompetent or feelings of not being needed, was expressed. A demanding work situation was often accompanied by a challenging private situation.

Everyday life was perceived as strenuous, with energy depletion and a feeling of being behind schedule. While describing satisfactory coping with everyday life, 'warning signs,' such as crying at night, feeling a high level of stress over time, becoming more easily irritated, feeling blue and struggling to master work–life balance, were also experienced (table 2). This group of doctors was so exhausted physically and emotionally that some felt grateful to be able to stay home from work with a sick child or even expressed that they hoped for a fractured leg to claim a 'legitimate' reason to obtain sick leave. In addition, they could feel worries concerning their work, or be unable to enjoy their leisure time because they were constantly thinking about work (table 2).

> I thought I would be able to enjoy my leisure time more than I do. I feel that I take work home with me every day, always something to think about, a patient you feel uncertain about. (Interview 6)

Fear of not coping any longer

Doctors in this category described unreasonable stress and/or conflict in their lives and going out of their way to accomplish what was expected of them both at home and at work (see table 2). Understaffed workplaces and expectations to work very long hours could lead to doctors being unable to take leave or sleeping very little. To cover for colleagues who were on vacation, some doctors overworked to a state of exhaustion. This exhaustion could even outlast their subsequent time off. In addition, serious conflict or power struggles with colleagues or management could cause isolation, loss of important work tasks or exclusion from taking part in reorganisational processes and meetings. Fear of not managing the next stretch of working life was expressed.

These situations led to concentration problems, sleeplessness, hopelessness and even depressive symptoms. Struggling to find words, feeling nauseous and a constant feeling of exhaustion were expressed (table 2). The simplest everyday tasks, such as calling in a patient from the waiting room or shopping, were difficult. The perceived inability to cope led to feelings of not being able to take control of the situation and that there was an endless list of duties both at work and at home forcing them to constantly rush to complete the next task. At times, there was an experience of everything coming to a halt. Doctors described difficulties in completing a train

Table 2 Citations

	Concerned—looking for advice	Fear of not to coping any longer	Looking for a way back or out
Perspective and experiences	I would say that stress and lack of sleep and the ongoing need to perform causes something like increased stress levels all the time. And that can't be healthy in the long run, I think. *Interview 6* I hoped every day that I wouldn't have to go to work. I almost hoped I would fall and break a leg so that I couldn't go to work. I was almost relieved when my youngest, who had started kindergarten, fell ill and I could stay at home. So, in a way, there was never a day when I was okay with work tasks. I felt bad every day, and I cried on my way down to the car or at work—almost every day. *Interview 1* Yes, you could say that, but in many ways I have been and felt well during this time, I may have sometimes felt that the days are exhausting and heavy going, but I haven't felt sick. *Interview 9*	Not just work—I feel the situation is most difficult at home. But it's the total situation—capturing how one feels in trying to stretch oneself so far in all directions. *Interview 10* On a number of occasions in recent months, there were several things that I thought can't be normal. Sometimes I can't find words. *Interview 10* Okay, I have had high blood pressure in recent years. That hasn't really been a problem, but I think it is related to why I came to Modum (Villa Sana)—for depression, anxiety, and sleep problems. It was the same in May, when I hadn't slept for many nights, and I finally said that I felt I was no longer functioning well. I'm also beginning to be worried about making mistakes. *Interview 5* It was as if everything just stopped for a while, and it became so difficult. Everything seemed difficult, every day—dealing with patients, even shopping and sleeping, and so on. So then I thought, 'Oh God, I really have to do something.' *Interview 8*	Yes, I told her that I couldn't do it any longer, that I'm so scared of making a mistake with the patients. My GP recommended sick leave—I contacted my GP because I was no longer a doctor. I said to my boss that I could no longer handle the day, every day at work. *Interview 7* And yes, before, when things were difficult, there was always an extra gear that enabled you to push a little more, thinking it's only for a finite period of time, and that it will probably get better. A kind of wishful thinking.… And then you think, 'Now it will get better, now it will get better—I have to give and push even more…' And then, finally, there just isn't anything left to give, and that's a feeling I've never had before. *Interview 3* …these depressive down periods are so frightening. I get… with this one, I also experienced strong suicidal thoughts, so I would say it's serious depression. *Interview 4* I don't feel like a doctor. I just feel like a patient who is very scared. *Interview 7*
Expectations of help	It's described as a course, so I understood that this is not therapy–that much I knew for sure. *Interview 1* And then I was a bit scared of having unduly high expectations. So I just told myself that it would be a day to sort things through in my mind, in the hope that we—that I—can understand the situation better. *Interview 9* I found it extremely helpful to talk to somebody who, I suppose, knows the profession, and understands what you could call the 'lifestyle'—what a doctor's life is like. That was very reassuring. And [that it was someone] who had talked to others in similar situations. [It was] good to know that I was talking to someone who was experienced in that field. *Interview 6*	I thought that it [Resource Centre Villa Sana] was perhaps only a place to start… where one could reflect on the situation, possibly for more than one day…if that was needed. *Interview 8* … this is a kind of introduction, where you get to know about your possibilities. You learn some terms; you discuss and reflect; you develop some thoughts. You get some counselling, and some pegs to hang things on. *Interview 11* I thought it [coming to the Resource Centre] might be important to get some tools for [handling the situation]. *Interview 10*	… I didn't think that medication would be discussed or evaluated during the counselling session. No—I thought it would be advice about the future, perhaps including treatment by a psychiatrist. *Interview 4* If accepted at Villa Sana, I hoped to get some peace of mind, some counselling. *Interview 7* I think my expectations of Villa Sana differed from what I got… I know I was thinking 'Okay, I need something tangible. I need a date for when I can get back to work; I need new medication.' *Interview 13*

Continued

Table 2 Continued

	Concerned—looking for advice	Fear of not to coping any longer	Looking for a way back or out
Barriers and facilitators	**Confidentiality:** … it meant a lot to me that there would be no record (of the counseling session). *Interview 6* …so I thought that was good—because she didn't adopt the therapist role. It was a conversation—it wasn't logged, and it felt very agreeable, as well as extremely professional. *Interview 9* It's not important. He said he wouldn't be writing a medical record, but it wouldn't have mattered to me if he did. *Interview 12* **Sick leave:** I've never had a GP. I [once] had gallstones, which needed to be removed, so they took out the gall bladder. I haven't been on sick leave related to that or anything else, other than a few self-reported days off. *Interview 6* **Threshold:** I hesitated [to contact the Villa Sana Resource Centre] because, first of all, I thought that this counselling was reserved for people on sick leave. Secondly, I thought that it was more specialized care [at the Resource Centre]. *Interview 1* No, I can also contact my GP, but this was not an appropriate issue [for the GP]. I don't have a high threshold for asking for help, which may be atypical for a doctor. *Interview 12* I think perhaps [the threshold for] seeking help from a GP or other parts of the health care system is much higher for me than [seeking help] at Villa Sana, but I wouldn't say the threshold for contacting Villa Sana is low. I've thought about it for a long time, but I didn't want to do it because I thought that, to do so, I would have to have a much more serious mental condition. *Interview 6*	**Confidentiality:** …No, I trust the confidentiality in patient records. I'm not concerned about that. *Interview 8* Yes, I think it's really important. It lowers the threshold (for seeking support)…. *Interview 11* **Sick leave:** I haven't ever really been on sick leave. I was on partial (20%) sick leave for a short while because of exhaustion and stress at the end of my third pregnancy…deep inside, it feels difficult to view sick leave as the solution to anything at all. *Interview 10* No, I can't stay away, I feel I have to go to work. If I'm away, someone else has to do extra work, or my colleagues have to stand in for me if I'm not there. So it doesn't feel okay [to be on sick leave]. *Interview 8* **Threshold:** So it was a bit random [contacting Villa Sana]. I was in a group professional guidance setting, and one colleague there had been to this counselling session in Oslo. So then I thought 'That's doable! I can't get away for a week, but I can use one of my administrative days and attend counseling.' *Interview 8*	**Confidentiality:** It works as an offer of wellness because this is not therapy, and no records are kept. Because we come as a result of serious overload and are not in treatment, we attend a course … for reflection. So that and the guarantee of confidentiality encourages us to muster our strengths. *Interview 2* I felt I was as low as I could get, and I had so many patient records …in different hospitals, so keeping up a façade is kind of too late, you know. One more or less didn't matter to me at that time, but I know it matters to other people. *Interview 3* … I think that might be important in keeping the threshold low [for seeking peer support] for all kinds of problems—and because it's clear that some things are difficult to talk about, [people might not] make contact if everything was to be recorded. Then, either the Norwegian Labour and Welfare Administration or supervisory authorities could ask for information….If [the service] is to protect people who struggle with alcohol or drugs or serious psychiatric illness …or with things even more difficult than I am struggling with [it is important that records are not kept]. *Interview 4* Yes, it is important. I hope I can look back at this and see it as a state of emergency. *Interview 13*. **Sick leave:** It was a very difficult decision to accept sick leave. In the end, I realized I'm a patient now, and I have to let my GP take care of me. *Interview 7* **Threshold:** I've had colleagues who mentioned Villa Sana, but it was my GP who asked me on multiple occasions to get in contact [with Villa Sana]. *Interview 3* There's a long way to go from first realizing that there's a problem to realizing that one has a problem. And then, it's a long way from there to accepting that one has a problem—and an even longer way to seeking help for the problem. That whole process is really a kind of recognition that one doesn't cope by oneself. *Interview 3*

GP, general practitioner.

of thought, becoming anxious about the next patient and experiencing a reduced quality of life (table 2).

> What's been such a dilemma for me is sick leave or no sick leave. And it has been through the last 3 years. (Interview 5)

Looking for a way back or out

Characteristics that fit into this category generally illustrate the significant pressure on doctors, such as long work hours and serious incidents (eg, patient suicide, murder threats or media exposure), often in combination with depression. These doctors had been diagnosed with either a somatic or psychiatric condition and were not working at the time of the interview. Often, they had hid serious symptoms while attempting to 'normalise' their condition. Some believed that they had to cope with the stress, as they assumed other colleagues did. However, finally, pain or reduced function prompted support seeking.

Sleep disturbances, anxiety, pain and depression were common. There were experiences of deterioration of memory and difficulties in performing simple practical tasks. Work had consumed all their energy and doctors described giving up exercise and becoming socially isolated. Self-harm and despair due to a situation not compatible with normal life or work activity led to serious suicidal thoughts (table 2). There was a fear of repercussions for needing accommodations at work. Some worked with a feeling of numbness. Doctors described being pushed to take on more patients than they felt they could handle and making mistakes resulting from lack of focus.

> I think the worst experience I ever had was when I went on sick leave. It was the same feeling as giving up. I felt totally powerless. There were no options. (Interview 3)

Doctors' expectations of the help they would receive

Expectations to the help they would receive varied widely. Some doctors had limited clarity about what kind of help they could expect. Others did not really know what kind of help they needed (table 2). They all knew that the peer-support service is a doctor-specific service outside of the public healthcare system.

Doctors in the category 'Concerned—looking for advice' sought peer support primarily for guidance. It was important to meet a non-judgmental professional, outside of their own professional setting, who could provide advice and input (table 2). They expressed concerns that a more serious situation might arise if they did not act to cope with their issues in a better way. Some examples of expressed needs were hoping to receive advice, managing a work transition, seeking help to sort a situation with too many part-time jobs, or discussing if they should take advantage of their sabbatical leave to take care of their mental health.

Doctors in the category 'Fear of not coping any longer' considered seeking peer support as a place to start, hoping it could enhance their understanding of what the next step toward a better life should be. They sought advice or 'tools' for handling the current situation (table 2). Through counselling a need for referral to therapy could be revealed, and if so disappointment was expressed that the peer-support service did not offer treatment or referrals.

Although the doctors in the category 'Looking for a way back or out' had been in contact with the healthcare system, were diagnosed and were on sick leave or out of work due to their situation, they acknowledged a need for more help. There were hopes to access this through the counselling service, for example, through referral to a specialist (table 2). Ways to resume work, specific input about career changes and assessments concerning psychotropic drugs were among the presented needs. There was also a need for help to learn more about how to handle crises and trauma in private life and to handle the pain transferred from patients and patients' relatives.

Barriers and facilitators

As the empirical material revealed a wide range of opinions within and across the three categories concerning barriers and facilitators, see table 2, these findings are summarised here.

Regarding the importance of confidentiality in the peer-support service, participants' opinions differed. Some believed it was fundamental that the service be completely confidential so that no records could be accessed by colleagues or governing services. For others, it was not important whether a medical record existed or not (table 2). Some participants wished that there was a medical record, as this would have facilitated referral to further treatment. Others expressed that confidentiality promotes an important attitude in the counsellor about acting as a peer and not as a therapist (table 2). The confidential setting was seen as lowering the threshold to seek help, which was considered useful especially in reaching out to colleagues suffering from alcohol or drug abuse.

Sick leave was difficult to embrace. Interestingly, doctors who experienced a low threshold for seeking peer support were still reluctant to take sick leave when they felt unwell. The empirical data revealed an attitude towards sick leave as a practice that should be avoided if possible. They characterised leaving their work tasks as showing disloyalty to colleagues and patients even when sick leave is necessary (table 2). Those who were on sick leave or out of work described their struggle to keep up with work until they reached a tipping point (table 2). Not being able to work as a doctor was experienced as a loss of identity and described as a weakness, which was considered equivalent to 'giving up.'

Doctors who sought help as a preventive measure described this behaviour as 'atypical' of doctors (table 2). They had a low threshold for reaching out to the peer-support service—lower than for contacting the healthcare

system. However, they had given a lot of thought before reaching out for peer support. Others considered the threshold to seek peer support as high and had struggled with distress for months to years before seeking help. Those who had previously sought help from the healthcare system due to the issue at hand opted for peer support as a supplement to regular treatment, not as a primary preventive measure. The doctors were aware of the services mainly due to a recommendation from their GP or a friend (see table 2).

DISCUSSION

This study reveals various reasons why and when doctors seek peer support. Three categories emerged from the rich empirical material: 'Concerned—looking for advice,' 'Fear of not coping any longer' and 'Looking for a way back or out.' Some of the doctors had sought support at a stage where it was possible to stop development towards ill health and burnout. Others had been clearly in need of support due to serious health or work issues that they were experiencing. However, why doctors turn to a peer-support service for help cannot be linked exclusively to the three categories presented above nor to the doctors' expectations of the help they would receive. This must be understood in light of experienced barriers to and facilitators of seeking peer support. This is further discussed below.

Strengths and weaknesses

An important strength of this study is that it promotes an increased understanding of how doctors reflect when seeking peer support by depicting information-rich, illuminative categories. The selection of eligible doctors based on gender, age, specialty, and demographics yielded descriptions of a wide range of help-seeking behaviours.

Arguably, 13 participants constitute a small sample size. However, Patton states that 'Qualitative inquiry typically focuses in depth on relatively small samples, even single cases (n=1), selected for a quite specific purpose.'[28] In this rich empirical material, there was a sense of saturation after approximately 10 interviews and 3 more were added. Of course, there can be other experiences in other situations.

As there is no information about those who declined to participate in the study, the results could be biased. Possibly, doctors with severe exhaustion or who were very reluctant to share private information did not consent. However, it is important to emphasise that the interviewed doctors did share sensitive information that can create resonance and a sense of undeniability for the reader.[32] Although this study was done in Norway, it dealt with common factors, such as doctors' reluctance to seek healthcare and a demanding work–life balance,[13 33] that have been documented in many studies in Western contexts. The phenomena described are, thus, general and relevant beyond the group of doctors interviewed in this study, as described by Wenger's theory of occupational community of practice.[34] As such, the results have transferability to settings where doctors seek peer support. In light of the 'burnout epidemic' described in the USA and other Western countries, we need more qualitative knowledge of doctors' help-seeking.

The fact that the first and last authors are doctors themselves and have practiced as peer counsellors probably facilitated recruitment through credibility and also facilitated the interviews through firsthand knowledge of peer support. Nevertheless, bias may arise when investigating one's own organisation,[28] through omitting relevant questions or modes of exploration, as this might be part of the researchers' tacit knowledge. This bias was counteracted by two of the coauthors having a non-clinical background, but extensive insight into the field of medical professionalism. The internal validity of the data were ensured by letting participants read the results section and approve citations. A user representative (a doctor who has sought peer support from this service) was involved in the planning of the study and project description and provided feedback on this paper.

Barriers to and facilitators of seeking peer support

Threshold

The threshold for seeking peer support varied from low to high. Doctors identifying the threshold as low characterised this attitude as an 'atypical behaviour.' They had turned to peer support for guidance and did not express expectations of further treatment. Identifying the threshold as high was associated with severe symptoms and late help-seeking behaviour. Numerous factors contributed to a high threshold. In accordance with previous studies, participants unfavourably comparing themselves to colleagues who seemingly coped well with their challenging daily lives discouraged them from seeking help.[35 36] Concerns regarding confidentiality and fear of being labelled as unwell contributed to a higher threshold and were congruent with barriers identified in previous studies of why doctors avoid or postpone seeking medical care.[6 36] A recommendation from their GP or from a doctor friend who had attended the programme was a strong enabler of reaching out. In fact, all but one of the participants attended peer support after receiving a recommendation from a fellow doctor. It appears that the decision to seek peer support was regarded as difficult, although not as difficult as deciding to use healthcare services.

Confidentiality

Norwegian peer-support services are preventive and the programmes guarantee complete confidentiality.[10] As the service is not referral-based, there is no preselection. This contributes to the wide spectrum of problems and needs found in this material. The lack of formal notes or records represents a double-edged sword. To some, confidentiality is a premise that enabled them to reach out to the service, lowering the

threshold. Others noted the benefits of a formalised record, which could have provided the opportunity for referral to treatment. Yet other participants already had patient records in public healthcare, trusted that the records would be kept confidential, and therefore, expressed a neutral attitude towards the question of confidentiality. These findings reflect a potential dilemma between expectations (eg, referral to treatment) and the preventive nature of the peer-support service.[37]

Several participants emphasised the importance of keeping the services completely confidential to facilitate help seeking for those who struggle with drug or alcohol abuse or severe mental illness. Internationally, confidentiality in peer services for doctors is solved in a range of ways, from treatment programmes with medical records tailored for doctors as patients[38 39] to peer-support programmes practicing confidentiality, but the latter have limited confidentiality to prevent harm to the doctor or patients.[7 8] This places the Norwegian services in a position of emphasising confidentiality more than other peer-support services. In studies conducted in other countries, doctors suffering from burdens parallel to those of some participants in the present study were admitted to the hospital for treatment.[38 39]

Sick leave

Numerous studies have documented doctors' reluctance to take sick leave when they need it.[6 36 40] Several factors contribute to this reluctance, but an underlying cause could be the need for a fundamental shift in perceived identity: a salesman does not become a customer on falling ill, whereas a doctor must step out of their professional role to become a patient. For many doctors, going to work while feeling unwell is considered an attribute; stories of colleagues battling heroically through the workday, despite fever or pain, are numerous.[40] In this study, across all three categories, sick leave was not thought of as a viable option. Among doctors who were on long-term sick leave or out of work, inability to work as a doctor was voiced as a loss of identity. Indeed, some sought peer support as a supplement to public healthcare specifically in search of advice on ways to resume work as a doctor within a framework that supports work–home balance and mental health. Even though the peer-support service does not offer specific career guidance it can be a useful supplement to discuss career options. There seems to be a need for more flexible work hours, including the possibility of part-time work. Getting back to work can restore the previously mentioned sense of lost identity. Studies have shown that doctors demand of themselves to be 'fully capable.' However, this socialisation into a professional culture of altruism and invulnerability can make it challenging for doctors to take responsibility for their well-being. Young doctors now advocate an emerging new work identity, with a greater emphasis on self-care and work–home balance.[13 16 23]

Since the late 1980s, concerns about doctors' reluctance to seek help for health issues have been reported.[41] Despite increased awareness around this issue and the subsequent introduction of preventive peer-support programmes in several countries, this study found that all participants, to some degree, prioritised work at the cost of personal life and health. There are several reasons for this. For example, doctors find it challenging to assess their illness and carry out their work while feeling unwell because they prioritise their patients and colleagues. Younger doctors report fears of missing out on certain procedures and important learning as well as an element of competitive presenteeism.[5 40] There is also a culture of self-treatment and seeking medical advice from doctors who are family related.[42 43] For many doctors, a personal mental struggle is perceived as a weakness; thus, help seeking can be stigmatised. To mitigate this, doctors sometimes search for more 'appropriate' motives to seek help when required. According to Gjæver *et al*, doctors divide illness into 'respectable illness,' such as infections, stroke and cardiac infarction, and illness considered not legitimate enough to miss work, such as chronic and mental illnesses.[40] Many of these considerations were apparent among participants in this study and explicitly contributed to the postponement of adequate help-seeking.

Implications

The empirical material in this study, as well as several previous studies, demonstrated doctors' tendencies towards symptom minimisation, self-medication and reluctance to seek support, especially for mental health issues.[44 6 45] This underlines the pressing need for an organisational culture change in the medical profession to enable doctors to reach out, expose vulnerability and be human. Doctors should not consider help seeking as a sign of weakness or attempt to find 'somatic' reasons for missing work. It appears unreasonable that our society nourishes an understanding of 'the good physician' as altruistic and compassionate, yet simultaneously pushes doctors to adopt a judgmental attitude towards their own distress. This discussion should be of value to employers in healthcare, doctors' associations, the community of doctors and organisations providing counselling services for doctors in other countries.

CONCLUSION

This study identifies how help-seeking doctors reflect on a range of situations leading them to access a peer-support service and their expectations of the service. Despite comprehensive research on the risks of burnout and distress among doctors, and the institution of low-threshold peer-support services, doctors hesitate to seek help. Why doctors seek help at a given time appears to be influenced more by their perceived threshold to reach out, their beliefs concerning confidentiality, and their

attitudes towards sick leave than by symptom severity or worries about their condition.

Further research is warranted to understand doctors' experiences of the ability of peer support to meet their range of expectations. Thus, follow-up interviews are therefore planned.

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Competing interests None declared.

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Paper II

Paper III

BMC Health Services Research

RESEARCH

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Understanding peer support: a qualitative interview study of doctors one year after seeking support

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Abstract

Background Doctors' health is of importance for the quality and development of health care and to doctors themselves. As doctors are hesitant to seek medical treatment, peer support services, with an alleged lower threshold for seeking help, is provided in many countries. Peer support services may be the first place to which doctors turn when they search for support and advice relating to their own health and private or professional well-being. This paper explores how doctors perceive the peer support service and how it can meet their needs.

Materials and methods Twelve doctors were interviewed a year after attending a peer support service which is accessible to all doctors in Norway. The qualitative, semi-structured interviews took place by on-line video meetings or over the phone (due to the COVID-19 pandemic) during 2020 and were audiotaped. Analysis was data-driven, and systematic text condensation was used as strategy for the qualitative analysis. The empirical material was further interpreted with the use of theories of organizational culture by Edgar Schein.

Results The doctors sought peer support due to a range of different needs including both occupational and personal challenges. They attended peer support to engage in dialogue with a fellow doctor outside of the workplace, some were in search of a combination of dialogue and mental health care. The doctors wanted peer support to have a different quality from that of a regular doctor/patient appointment. The doctors expressed they needed and got psychological safety and an open conversation in a flexible and informal setting. Some of these qualities are related to the formal structure of the service, whereas others are based on the way the service is practised.

Conclusions Peer support seems to provide psychological safety through its flexible, informal, and confidential characteristics. The service thus offers doctors in need of support a valued and suitable space that is clearly distinct from a doctor/patient relationship. The doctors' needs are met to a high extent by the peer-support service, through such conditions that the doctors experience as beneficial.

Keywords Doctor health, Qualitative research, Health services research, Health workforce, Peer support

Background

Ensuring that doctors remain in the workforce is of the utmost importance with respect to sustaining and developing health services as well as with regards to providing the best possible healthcare to patients [1]. In this context, research has found troubling numbers of decreasing satisfaction and increasing burnout among doctors [2, 3]. Doctor burnout is associated with lower quality of

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care, increased turnover, more frequent medical errors and lower patient satisfaction [4–8]. Doctors' health and wellbeing are also important for individual doctors [4, 9–12] and their families. To lower the threshold for seeking help, as doctors are hesitant to seek regular treatment [13–16], peer support services are provided in many countries.

Peer support is a general description of a concept that initially was used in terms of peers as fellow patients. The NHS defines peer support accordingly: "Peer support is a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management" [17]. In the context of this study, peer support is used to describe support from someone with the same professional occupation, but not in the form of a doctor-patient relationship. This type of support can take the form of advice, mentoring, or simply providing a listening ear. In this manner, peer support can lower the threshold for help-seeking as it is a meeting between equals and not treatment. Peer support services may be the first place to which doctors turn when they need help and advice relating to their own health and private or professional well-being [18, 19]. This paper discusses the ways in which a peer support service can meet the needs of doctors who seek help.

Historically, peer support programs date back to the 1970s in the US. police force [20]. In response to reports of poor mental health and increased suicide rates as well as a growing concern for doctors' wellbeing in the early 1980s, several Physician Health Programs (PHPs) were institutionalized in the US with the aim of preventing malpractice behaviours, mainly in the context of offering treatment of drug and alcohol misuse. PHPs have evolved into effective treatment programs; the success rates found in PHPs significantly exceed those of other addiction care practices [14, 21, 22]. Based on these PHPs, low-threshold collegial services emerged to provide peer support to doctors. Many peer support services are run by doctors on a voluntary basis and practice strict confidentiality. Internationally, peer support services feature different degrees of surveillance and support as well as varying degrees of emphasis on confidentiality [21, 23–25]. Several services do offer confidential support and counselling, although one common limitation is that confidentiality may be broken if a patient's health is at risk or if a breach is deemed necessary because of serious concerns for the safety, health or welfare of the doctor or another person [26–28]. Norwegian initiatives in this context go far in keeping confidentiality to facilitate for doctors to speak openly.

The peer support service studied in this research is a locally based nationwide peer support network in Norway that is accessible to all doctors and medical students. This network includes approximately ninety dedicated peer supporters across all eleven Norwegian counties. The service markets itself as "an outstretched hand from colleague to colleague", is free of charge and does not require membership in the Norwegian Medical Association. On the homepage of the Norwegian Medical Association, contact information such as the names, e-mail addresses, phone numbers, towns of residence, and medical specialties of the peer supporters is accessible [29]. The service offers up to three counselling sessions with a peer, and the peer receives monetary compensation from the Norwegian Medical Association. Peer supporters guarantee confidentiality and retain full discretion regarding the information with which they are entrusted. The doctor seeking support freely chooses the peer supporter they reach out to. The service is trust-based and thus no record or identification system is in place. Although the number of conversations with each peer supporter is limited to three, the help-seeking doctor can freely seek another peer supporter for additional support.

The service does not provide medical services, i.e., no medical records are kept, and no sick notes or medical prescriptions are provided. The regular setting of peer support is by a face-to-face meeting. Some doctors seeking support may not want to or are not available for meetings. In these cases, the support may be given by phone or even video link. The peer supporter and the doctor together are free to choose which meeting modality they prefer. The design of the service thereby signals expectations of an informal setting, a safe framework featuring confidentiality, and an open conversation characterized by equality between peers rather than a doctor–patient relationship. A booklet [30] describing the role of peer supporters is published on the service's internet page. Here, the peer supporters and help-seeking doctors can find practical advice about the service's organization and guidelines, for example a description of the confidentiality. For training and quality assurance of the service, the peer supporters must participate at a 2-day, annual national meeting at least every third year. Here they practise giving support by role play and discussion of cases. They also have lectures, case discussions and exercises on the agenda. In some counties, there are additional local meetings for the peer supporters providing an arena for debriefing, supervision and support. The supporters are recruited by appointment of the local medical association in each county. It is considered desirable that a variety of medical specialties are represented among the peer supporters to ensure a broad diversity of collegial needs to be met. Sometimes a peer supporting session is followed by a formal, medical consultation after agreement by the doctor seeking support. This option is also described explicitly in

the role description information booklet [30] and is often discussed at the regular, annual meetings of the peer supporters. If this transition takes place, from that point on, the conversation is regarded as a regular medical consultation. Specifically, the peer counsellor changes roles from that of peer supporter to that of medical professional, with all legal and professional duties entailed by the latter.

Long-term studies of PHPs have been conducted [31–33], but only a very limited number of long-term studies have investigated the possible benefits of peer support on doctors. A longitudinal Norwegian study found improved mental health among doctors up to 3 years after attending a peer support service, Villa Sana. That study reported a reduction in doctors' levels of burnout, job stress, and symptoms of depression and anxiety both 1 and 3 years after their contact with peer support [11]. In a previous qualitative study of the Norwegian Medical Association's locally based peer support service, the usefulness of peer support for doctors was investigated by interviewing the people providing the service, i.e., the peer supporters [34]. This study concluded that it is necessary to interview individuals who have used the service in order to obtain new knowledge regarding peer support and the ways in which it can meet doctors' needs. A lack of qualitative studies in the field of doctors' mental health and wellbeing indicates the need for more explorative and interpretative investigations of this context.

In medical culture, doctors have expectations of being able to cope, to endure, and to avoid suffering from mental illness or showing weakness [35, 36]. This aspect of professional medical culture is often referred to as "the hidden curriculum" [37, 38]. Within such a culture, it can be difficult to feel sufficiently safe to show weakness, insecurity, or illness at work. The design of the Norwegian medical association's locally based peer support service emphasizes the fact that doctors should be able to speak openly without incurring negative consequences, to ensure a low threshold for doctors who are hesitant to seek help and to offer a venue that is free from the hidden curriculum as well as the traditional doctor–patient relationship [30]. To better understand how a peer support service can meet the needs of help-seeking doctors in such a context, it can be useful to consider Edgar Schein's theory and thoughts regarding ways of providing psychological safety and the way norms and culture develop within an organization.

Theory

Conceptions of psychological safety and the development of norms in a social environment according to Schein

Psychological safety is an expression originally stemming from Willian Kahn [39] and later described by Amy Edmondson as "people's perceptions of the consequences of taking interpersonal risks in a particular context such as a workplace" [40, 41]. By utilizing this theoretical lens, we can explore whether the way in which the peer support service studied is designed and practised contributes to "psychological safety". Additionally, we can gain knowledge about doctors' thoughts regarding the interpersonal risk they take when they seek support.

In an environment with a lack of psychological safety, the energy, creativity, and potential for development that can be obtained by sharing thoughts is lost. Schein [42] discusses the presence of psychological safety in organizational cultures as necessary for changing and improving a social environment. It is the management's responsibility to provide a psychologically safe environment, which entails ensuring that subordinates feel sufficiently safe to express their thoughts and opinions. Psychological safety is closely linked to norms of interpersonal communication and sharing of thoughts in professional organizations. Norms function as decisions or rules within a group. Norms can be expressed through formal rules or guidelines (formal norms) as well as cultural expectations (informal norms). On some occasions, these formal and informal norms are in agreement, while on other occasions they are not. According to Schein, an occupational setting includes norms pertaining to a broad range of issues, including how to deal with problems with authority, how to establish workable peer relationships, how much emotion to display, whom to ask for help, and with what issues it is appropriate to ask for help [42]. The hidden curriculum [43] describes certain informal, often unspoken norms that make it difficult for the doctor to expose emotions, weakness, and illness or to admit mistakes in a professional medical setting. The conclusion of a paper by Tait Shanafelt and Schein that discussed several of these elements is that change is necessary to "heal the professional culture of medicine" [44].

Psychological safety is considered to be a basic interpersonal need at the workplace to foster well-being and personal development. Like all basic needs, if the need for psychological safety is not fulfilled in one place (the workplace), the workers will seek to fulfil it somewhere else. This paper studies and discusses the ways in which a peer support service for doctors might contribute to satisfy these needs.

Aim

We investigated the reasons why doctors sought a peer support service and the ways in which such a service could meet the needs of doctors who seek help.

Methods

For this study, approximately 450 consent forms for participation were provided to the peer supporters working for the service (90 peer supporters × 5 consent forms

each). In accordance with the study design, the peer supporters recruited doctors attending the service with at least one meeting, during the period January–December 2019. The peer supporters chose freely if they distributed the consent forms to the help-seeking doctors. It was the responsibility of the doctors to complete and post the forms. This mode of recruitment was the only one available to us as the peer supporters practise confidentiality and cannot share identifying information. In this manner, the help-seeking doctor chose freely whether to engage in the research project and thus to share sensitive information. Of the 450 consent forms distributed to the peer supporters, 22 consents were returned. When we started recruitment in January 2020, several doctors had difficulties to take time out of their busy schedules to meet face-to-face and thus withdrew from the study. After the Covid -19 pandemic arrived recruiting for online interviews was easier. This resulted in 12 interviews, see Table 1.

The interviews were conducted a year after each individual's attendance to peer support (±20 days), as planned, during 2020. The mode of recruitment used in this study represents a criterion-based case selection, the only criterion being attendance at the local peer support service in 2019 [45]. The first and last authors, both females, conducted semi-structured interviews lasting between 50 and 90 min. Ten interviews were conducted on-line with video and two interviews were conducted by phone according to the interviewees wishes. Interview data were complemented by supportive notes to aid discussion of perspectives and interpretations after each interview. The interviews were audiotaped, not videotaped, and transcribed by a trained research assistant. In the study design, the interviews were planned as face-to-face meetings but had to be re-scheduled as mentioned above, due to national rules during the COVID-19 pandemic in 2020 rendering physical meetings impossible.

Table 1 Participants

Characteristics of the selected participants (*n* = 12)	Participants (n)
Gender	
Male	3
Female	9
Age (average 46 years)	
60–75	3
50–60	2
40–50	2
30–40	4
20–30	1
Medical specialty	
Family medicine	5
Surgical specialties (gynecology, otolaryngology)	1
Laboratory medicine (biochemistry, radiology)	2
Psychiatry	1
Internal medicine (geriatrics, internal and occupational medicine)	3
Work experience	
0–10 years	4
10–20 years	5
20–30 years	1
30 + years	2

Qualitative research methods facilitate the investigation of experiences, beliefs, and values. The systematic collection, organization, and interpretation of interviews make it possible to explore the meanings of social phenomena as they are experienced by individuals themselves.

After reading through the empirical material, the preliminary themes were identified and discussed between all authors. The texts were analysed using NVIVO software with systematic text condensation [46], as described in Table 2, by the first and last authors in cooperation. This produced generalized descriptions in thematic code groups reflecting among other things the characteristics sought by doctors from the peer support service. Concerning reflexivity, the interviewers are both doctors (with specialty in occupational medicine and in psychiatry) and thus shared tacit knowledge with the interviewees regarding medical culture and professionality must be assumed. This is a strength as it facilitates understanding the interviewees situation but can lead to lack of questioning of cultural phenomena taken for granted within the profession. Both interviewers work as counsellors for colleagues (in another service) and are thus also trained in non-therapeutic dialogue, as well as having conducted qualitative interviews in the past. The first author is a PhD candidate, the last author is a senior researcher, PhD. The participants received oral and written information about the project and the interviewers. The co-authors are the user representative (also a doctor), a professor in political science teaching research design and health policies and a post-doc in medical sciences with research areas including doctors' professional identity and professional fulfilment. The descriptions and concepts were discussed among all five authors until consensus was reached. Finally, the first author applied these concepts to an analysis of all the interviews. This analysis was data-driven, although it was supported by theories of organizational culture to improve our understanding further. The results section was sent to the interviewees, who approved the text and the citations and did not suggest changes. Table 2 demonstrates stepwise the analytical approach.

Table 2 Procedures for analysis according to Systematic Text Condensation [46, 47]

1. Total impression – from chaos to themes	Reading through the material to get a general impression of the whole. Looking for preliminary themes associated with the research question
2. Identifying and sorting meaning units – from themes to codes	Identifying meaning units, give them a code. A code is a label gathering connected meaning units into groups
3. Condensation – from code to meaning	The thematic code groups across individual participants constitute an analytical unit for further abstraction by condensation of content
4. Synthesizing – from condensation to descriptions and concepts	From the condensates, we develop credible narratives that can make a difference by providing descriptions and concepts that inform the study question

Patient and public involvement

Patients were not involved in this study. A user representative (a doctor who had both sought peer support and served as a peer supporter) was involved in planning the study, writing the project description, analysing the data, and co-authoring the present paper.

Results

Although the doctors sought peer support for a variety of reasons, they all had difficulties managing their work situation in combination with private stressors. They expected support on an equal basis from a peer who could understand their situation. It was important that the peer supporter and the setting was distinct from a doctor-patient relationship and offered a psychologically safe space for the conversation. Below, we elaborate these findings in three main categories.

Reasons for attending peer support

The doctors sought peer support for a variety of reasons, but they all mentioned difficulties coping with their work situations and the desire to seek a "free space" to talk outside of the workplace. They discussed signs of burnout, such as fatigue, reduced work capacity and a feeling of being more vulnerable than before.

> *...I thought I had to get help to think differently in relation to my everyday life because I had reduced work capacity and felt much more vulnerable... Interview11*

The doctors sought advice concerning career changes, retirement, and illness. Some experienced a lack of support from and companionship with their colleagues. Others described bearing excessive responsibility, encountering anxiety linked to work, or feeling inadequate at work. They discussed ways of dealing with death threats from patients and challenges associated with taking up a new position or sought support after experiencing a personal crisis such as divorce. Some regretted having chosen the medical profession and asked for advice regarding ways of coping with work and a profession that they did not enjoy.

> *No, I guess that I didn't quite know how to handle being a doctor when I didn't have any desire to be one, and I also wanted to get some motivation to at least finish the internship. Interview 6*

Some doctors sought help with symptoms of depression, trauma or anxiety and deliberately reached out to a peer psychiatrist.

Hopes and expectations

Seeking support and understanding from a fellow doctor

The doctors used the service to receive support from a peer on an equal basis and to discuss ways of handling stressful situations at work or chaotic life situations. It was important that the peer supporter understood what it means to be a doctor.

> *I felt that the situation was sort of chaotic, and I probably hoped to get some help to sort through it and to get [...] thoughts from other doctors about how they would proceed in such a situation, for example, what would they have let go and what would they have focused on. Interview 3*

Doctors mentioned their experiences of a lack of sufficient support or feeling uncomfortable discussing their concerns at work. They noted that they did not know where else to turn to discuss work-related issues. They appreciated receiving feedback from a doctor who was not involved in their situation and who did not have a close connection to their place of work. Some doctors sought motivation and advice regarding how they could handle being a doctor despite their feelings of regret regarding their choice of profession. Several attended the service to deepen their understanding of their experiences of reduced work capacity and fatigue. A few sought specific advice regarding ways of solving different issues at the office and contacted a peer supporter who worked in the same medical specialty.

> *We discussed a lot of specific issues concerning practicalities, about the health secretary and how I*

could proceed there and what experiences she [the peer supporter] had. And yes, I got a bit of support [...] that it is tough to have leadership responsibility for employees as a GP. And that it is completely different than medical issues. So, I got some ideas about things that I am not very good at and with which I have no experience. That was a good conversation.
Interview 12

Some doctors specifically chose a peer who was a trained psychiatrist, either because they considered their issues to be primarily related to mental health or because they thought that a psychiatrist would have specific competence relevant to the issue at hand, for example, the receipt of death threats from patients at work and ways of handling that issue. Finally, peer support was used as a venue to discuss situations that were challenging in the context of both work and private issues.

I don't think it's okay [...] to talk about what is problematic at work. There aren't many I could do that with, I think, so that was probably part of the reason [that I sought peer support]. And I was exhausted and wondered what I could relate to work and what it was with me that just wasn't functioning.
Interview 7

Seeking psychiatric expertise

Doctors who deliberately chose to seek a psychiatrist as a peer supporter also sought advice regarding ways of coping with excessive workloads and challenges at work. Additionally, these doctors more or less expressed their intention to seek psychiatric treatment, despite the fact that treatment is not offered by the peer support service.

...but when I contacted her [the peer supporter], it was [...] both as a therapist and due to the fact that I didn't quite know what was happening to me, but it was in connection to work, and I thought it would be good to have chat with her and that she might have some input.
Interview 1

... I probably started to get depressed as well as very, very exhausted. I cried a lot, didn't remember the PIN to my credit card, went into the mall and didn't know where to exit. So, I think I just needed a person to discuss it with, who could give me advice, ideas on how to get out of it...
... I thought I needed a psychiatrist.
Interview 12

Some of the doctors were offered formal treatment and noted the existence of partially unclear boundaries between peer support and health care. Despite such unclear boundaries, the help-seeking doctors reported that they were cared for very well. In situations in which doctors hoped for treatment, they could experience disappointment if the peer supporter explicitly focused on a merely supportive role.

A relational space

Valued traits of peer supporters

The doctors appreciated meeting with a peer supporter who responded quickly and who was sufficiently flexible to meet outside of regular working hours. The opportunity to influence the decision regarding where and when to meet was highly appreciated by the help-seeking doctors. The peer supporters were perceived as trustworthy, which enabled openness in the context of difficult topics. Being met with courtesy and respect and being given the time necessary to unburden themselves were described as key assets by a peer supporter.

For me, it was decisive that he (the peer supporter) recognizes my problem and sets aside time.
Interview 9

Some doctors valued the encouragement to speak freely, while others appreciated being asked interested questions by the peer supporter. Some reached out to a peer supporter who worked in a specific medical specialty for professional advice. Several experienced the conversation(s) with the peer supporter as an opportunity to find a way of coping with the situations they faced.

She invited me to come back, and she explained the framework for the service and all that. I just have to say, I'm very appreciative and very satisfied with all that. I felt a bit like, after a couple of conversations, it was as if I got back on my feet again [...] and that was very good.
Interview 7

Setting

The doctors wanted to be offered a setting that was distinct from the settings that typically characterize doctor/patient interaction. The meetings took place at the peer supporter's home, in the peer supporter's office or in a break room after hours.

Yes, I turned up at her office, I guess it was actually after work hours, and she offered to meet at her office or outside or in a café [...] That was also very nice because then it felt possible to choose something that felt okay to me.

Interview 7

One of the interviewees was only offered the opportunity to meet during regular working hours, which limited the number of meetings available to the help-seeking doctor due to conflicting work obligations. Several interviewees were offered something to eat or drink. It was emphasized that the setting should be safe and caring but should also feature clear boundaries, thus ensuring a balance between a professional and a private setting.

We had the conversations in her break room after working hours; it was peaceful and quiet there. It was nice not to be in an office, but we were in a break room, and she had some fruit and coffee, and the setting was very good.
Interview 11

One doctor chose to receive peer support by phone. One doctor was met with the same physical structures as those associated with a doctor/patient relationship; that is, the meeting was conducted at the office and the help-seeking doctor was not offered anything to drink, which caused the doctor to feel that inadequate care was provided.

…it would have been nice to have something that was a little more friendly and open and maybe a, I don't know, a cup of coffee or something that you can be offered when you get a haircut, for example.
Interview 8

Formal structure of the service

The doctors appreciated the fact that the peer supporter gave them a brief introduction to what the service could and could not offer. It was described as a relief to be able to step out of their regular roles as doctors or patients and to be given the opportunity to speak freely without the constraints that accompany a medical consultation.

…maybe it was less stigmatizing when there wasn't a medical record.
Interview 3

The confidentiality of the service was highly valued. The doctors noted that such confidentiality provided them with a sheltered space in which they could discuss work-related problems and difficulties involving their colleagues, since workplace culture could make it challenging or impossible for them to discuss these topics at work.

… I need someone to simply help me sort through my thoughts […] when things are kind of difficult at work, I almost don't know who to turn to.
Interview 7

In addition, the service was used by doctors who did not consider themselves to be ill or to have health-related issues that naturally belonged in a patient record.

If I had been ill, it would have been correct to keep a medical record, but just being human doesn't need to be recorded, I think.
Interview 6

Some doctors found it to be less stigmatizing to seek a type of support that did not involve any record-keeping.

It's a bit about being removed from the role of doctor and the role of patient and being allowed to talk about what is important to you. As soon as a medical record is mentioned out loud, it takes on a professional touch, which can perhaps defeat the purpose to some degree.
Interview 4

I didn't have the feeling that it (the issue at hand) was something that should be diagnosed, that it was more of a life crisis or what I should call it, something that everyone can experience without it being an illness.
Interview 3

Discussion

The main result of this study was that the doctors wanted peer support to be qualitatively different from that of a regular doctor/patient appointment. They sought support due to a range of different needs and discussed occupational, personal, and private challenges. They attended peer support either to engage in dialogue with a fellow doctor or in search of a combination of dialogue and mental health care by seeking peer supporters with psychiatric expertise. The doctors valued flexibility concerning where and when to meet, the lack of a medical record, a confidential setting, an informal setting that differed from the patient–doctor relationship, and the availability of sufficient time to allow them to speak freely. Some of these factors are related to the formal structure of the service (such as its confidentiality), whereas other elements are based on the way in which the service is practised and on regular discussions of, and consensus regarding this practice in formalized annual meetings among peer supporters.

Reasons to attend peer support

The broad range of reasons why doctors attend a peer support service reported by this research all include

involvement of issues at work as well as private stressors. This is in line with findings of previous research, which consistently report work-related difficulties to be relevant in this context [18, 19, 48]. Literature shows that the structure of the peer support offered, whether it is designed as peer support [18, 19] or as a coaching intervention [48], also influences the type of issues that are brought up by the services' users. Additionally, in this study, we found that peer support was used to meet a combination of individual needs and needs related to work issues.

Hopes and expectations

The empirical material demonstrates that interviewees' hopes and expectations were met to a large extent. The doctors searched for and received a friendly, inquiring, and attentive doctor colleague as well as an informal place to reflect. This description is in line with the motto of the peer support service: "An outstretched hand from colleague to colleague". The findings resonate with previous research where acknowledgment, reflective listening, and support are found to be essential qualities of peer support [49, 50]. The doctors sought dialogue and, to a lesser extent, specific input regarding ways of solving a problem. Through peer support, the participants were offered confirmation of their perspectives and experiences as fellow doctors. The empirical material indicates that the doctors wanted and received personal and professional recognition from the service. The sense of this personal and professional recognition was said to be due to the formal structure of the service, the context in which the service took place, and the traits of the peer supporters. This is in agreement with previous research which finds recognition to be an important condition to support physician engagement [51, 52].

Doctors' reluctance to seek formal health care, especially with regard to mental health difficulties, has been well documented [16, 53–57]. This is further confirmed in this study by the fact that doctors seek psychiatric expertise in the context of a peer support service that explicitly does not offer medical treatment. Based on the empirical material, we know that several peer supporters changed the context of the meeting(s), from offering peer support to offering a formal medical consultation. Thus, by attending peer support, some participants in our study received the treatment they actually needed. These doctors underwent treatment as a continuation of peer support, bridging the gap between collegial conversation and formal treatment. They described the combination between supportive and therapeutic roles at the service. Although this mixing of roles was characterized as unclear, they were highly appreciative of the support and treatment they received. This practice may offer both advantages and disadvantages; on the one hand, it can help ensure that the doctors' needs are met, while on the other hand, it may weaken a factor that many doctors experience as valuable, namely, the clear distinction between support and the doctor/patient relationship. A study of another Norwegian peer support service that did not offer the possibility of referring the receiver for a medical consultation, found that some help-seeking doctors had hoped for such a possibility [18]. To some doctors, peer support was the first situation in which they felt sufficiently safe to voice their mental health concerns to a colleague, and they would have greatly appreciated a seamless transition into therapy [18]. Taking this into account, the fact that the Norwegian Medical Association's' locally based peer support service offers a flexible service that can accommodate these different needs seems to be appropriate.

A relational space with psychological safety

It was clear in the interviews that the doctors lacked psychological safety at their place of work and sought an open conversation in a flexible and informal setting when attending peer support. Peer support offered by the Norwegian Medical Association has become a well-known institution to which doctors can turn for help [58, 59]. The service provides easy access to help with both work-related and personal issues. The fact that the Norwegian Medical Association owns and manages peer support services might reinforce and legitimize help-seeking. Peer support can function as a haven where doctors can discuss the problems resulting from conditions in the workplace. Part of the reason doctors benefit from this offer is the confidentiality and the provision of a psychologically safe environment.

Some researchers argue that psychological safety of employees, such as valued feed-back and openly admitting to mistakes, is not part of the organizational tradition in the field of health care [44, 60]. To create psychological safety, Schein suggests several activities that can be implemented including a focused dialogue with the goal of helping participants to relax sufficiently to examine their own assumptions and to be able to consider other assumptions as equally valid or true. The accounts of the manner in which the doctors were met at the peer support service are in accordance with a setting which fosters psychological safety as described by Schein [42]. Although peer support does not represent an identical setting to that of Schein's focused dialogue, it contains many of the same elements which are necessary to encourage reflection. Namely provision of resources and a safe space to discuss difficulties with someone with a similar background [42]. All the doctors included in this study noted that they felt sufficiently safe to discuss

their challenges when they attended peer support. The empirical material demonstrates the relevance of both personal characteristics (the peer supporter's approach to the problem) and structural features (the setting in which the conversations took place, the confidentiality of the service) to the experience of a safe framework and the opportunity to speak freely and openly. Previous studies called for the need to question professional norms and the underlying and often unspoken professional assumptions, the hidden curricula, that can hinder the doctor's ability to provide self-care [35, 36]. Peer support can thus help the doctor to initiate changes in his or her work and private life or seek adequate treatment. Simultaneously, confidentiality (and thus the associated safe framework) may prevent doctors from addressing problems and provide feedback at their workplace. It could be argued that a factor that allows individuals to benefit from the offer can contribute to limiting efforts to speak up and solve issues at the workplace.

Implications

Several topics emphasized in peer support conversations are known drivers of burnout among doctors: lack of support, fear of voicing concerns at work, excessive workloads, work–home conflicts, negative leadership culture and a lack of comfort with their amount of responsibility at work [3, 4, 8, 44, 61–66]. In the interviews, explicit statements were made indicating that speaking up at work entails taking a personal risk and that some of the interviewees did not know where else to turn for help with their work-related problems. This finding is in line with the conclusions of recent research suggesting that health care leadership must discover ways of increasing voice and decreasing silence among health care professionals [60]. Such an approach is likely to improve health workers physical and mental well-being.

In his theories, Schein notes that issues might arise with regard to commonly accepted norms pertaining to how to relate to each other, how to deal with problems with authority, how much of one's personal life to share, whom to ask for help and with what issues it is appropriate to ask for help [42]. To ensure psychological safety at a workplace, Schein suggests the implementation of support groups in which difficulties can be discussed with peers as well as the provision of resources, i.e., the allocation of time and space, necessary to facilitate coaching and the valid feedback that is required to create a psychologically safe space. Accordingly, the lack of a psychologically safe work environment should not be addressed exclusively outside the workplace. Individual doctors may manage to cope with the situation for some time by optimizing their own stress tolerance. Nevertheless, to support doctor well-being and prevent doctor burnout, it is important to ensure that the discussion concerning work issues and psychological safety also happens in the workplace, which is the venue in which many of the reported problems arise. For some issues, it could be considered whether the workplace needs change more than the doctors. It is the health care organizations' responsibility to provide workplace venues with sufficient psychological safety to address these important challenges and find strategies to create a sustainable work environment. Burnout, fatigue [8, 10, 61, 62, 67, 68] and decreased job satisfaction [4, 69–72] represent problems faced by doctors throughout Europe and the US, and must be addressed at both the individual and organizational levels [44].

This study adds further evidence to the knowledge that doctors are hesitant to seek help and that some of those attending peer support need healthcare. Further, the study narrates aspects important to help-seeking doctors to feel well taken care of when seeking help. Among those aspects are both the physical setting and the attitude and approach of the peer supporter. We think that this information may be of value to employers in healthcare, doctors' associations, the community of doctors and organisations providing peer support services for doctors internationally.

Strength and weaknesses/ethics

The digital interviews conducted made the task of information gathering challenging, as the interviews required participants to trust researchers sufficiently to disclose sensitive personal information. Such trust can be more difficult to obtain in the context of an on-line interview. On the other hand, when we started recruitment in January 2020, the doctors were reluctant to take time out of their busy schedules to meet face-to-face. In this period several of the 22 received consents withdrew from the study. After the Covid -19 pandemic arrived, in our experience, recruiting interviewees was easier when the appointment was on-line instead of face-to-face. Maybe as no one was required to travel to a meeting and the digital interview took less time from a busy workday. It is also possible that it was perceived as less invasive to meet digitally.

The sampling process may have led to selection bias. Both peer supporters (who delivered the consent forms) and individuals who sought support (potential participants) may have been sceptical regarding the study. It is possible that the deeply personal nature of the topics discussed in the peer support service led to lower response rates [73]. This is a weakness of the study which can reduce the internal validity. However, in a qualitative study, we seek richness and depth of

data that in this case describes a wide spectre of reasons to seek peer support and gives indications of how it is useful to offer peer support to doctors. The internal validity was further strengthened by involving a user representative who also has experiences from being a peer supporter, and by participants approving the quotes used. The relevance of the findings in this study is strengthened by similar findings in other studies [18, 19, 34]. This strengthens the generalizability of the results. Another weakness could be that some interviewees also received regular medical therapy at the peer supporters' office in continuation of the peer support. This may have influenced their recollection of the support provided.

The results presented are based on the condensates that include information across all the interviews pertaining to the relevant analytical unit. Additionally, we have used illustrative quotes to give examples. Although a few of the interviewees are not directly quoted, their data are thus still represented in the text. The direct quotes have been chosen as they are representative for the overarching findings of the data set. We chose quotes with an emphasis on theoretical generalization; quotes that illustrate the relevance of the theory used (psychological safety) as described in the literature.

Concerning reflexivity, the two interviewing authors are doctors and peer counsellors (although they do not work in the Norwegian Medical Association's locally based peer support service, but in a centralized service presented in a previous paper [18]). They are also members of the medical professional culture studied. This identity was important for making the participants feel at ease, but it may have led to bias since the authors were investigating their own profession [45]. To balance this bias, the author group additionally consisted of a user representative (a doctor and peer supporter) as well as two authors with different academic backgrounds, but extensive knowledge of the fields of medical professionalism, leadership and organizational change as well as qualitative research. The presence of a co-author who also is a user representative having attended peer support and who has worked as a peer supporter is a strength of this paper. This validated both participant experiences and provided expert knowledge on how the peer support service is managed in practice. The interdisciplinary analysis group has attempted to provide a rich and nuanced understanding of the empirical material [45]. The inescapable influences of researchers have been integrated into discussions concerning the recognition and interpretation of relevant topics, including the task of investigating one's own professional culture [74].

Conclusions

The peer support service studied in this research is aimed at help-seeking doctors with a variety of needs and provides a venue for discussing the challenges that result from both individual and work-related factors. These needs are met to a large extent by the peer support service, through conditions that the doctors experience as beneficial. Peer support can provide psychological safety by offering a flexible, informal, and confidential service that is clearly distinct from a doctor/patient relationship. Continuing the offer of a peer support service thus seems important although for some issues the need of change applies as much to the medical workplaces as to the doctors.

Abbreviation

PHPs Physician health programs

Supplementary Information

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Additional file 1. Interview guide - Reasoning about contacting peer support in 2019, interviews carried out 1 year later, in 2020.

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Authors' contributions

Contributors IMTH and KIR designed the study, carried out the data collection and analysed, interpreted and drafted the paper. CD, FV and FB participated in the study design and interpretation of data. All authors made critical revisions and contributed important intellectual content. All authors read and approved the final manuscript. IMTH is responsible for the overall content as the guarantor.

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Availability of data and materials

All data generated and analysed during this study are stored securely, offline at Modum Bad, Norway. The datasets generated and analysed during the current study are not publicly available due to the personal character of the interviews but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

All methods were carried out in accordance with relevant guidelines and the Helsinki declaration. The study obtained ethics approval from the Regional Ethics Committee (REC), Norway (REC ID number 2018/199). Prior to conducting an interview, a description of the study was provided, and a written and verbal informed consent was obtained from all participants. The interviewees were sent the results section including citations for review and approval before submission.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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