Implementation of a Near-Peer Support Program to Improve Trainee Well-Being after Patient Safety Events

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ABSTRACT

Adverse events can take an emotional toll on physicians, which, left unprocessed, can have negative impacts on well-being, including burnout and depression. Peer support can help mitigate these negative effects. Structured programs train physicians to aid colleagues in processing work-related experiences and emotions such as guilt and self-doubt. Although such programs are common for faculty, peer support for resident physicians has not been adequately addressed, and few programs have been described in the literature. Residency is a vulnerable time of professional identity formation, and providing support has specific challenges. The power dynamics and distance between lived experiences limit the utility of faculty peer support programs. Some institutions have trained residents to provide peer support, but widespread implementation may be difficult because of limited resident time and comfort in providing support. Chief residents (CRs), however, are close to residents in training yet experienced enough to afford perspective and are uniquely situated to provide "near-peer" support. We describe the implementation of a CR near-peer support program in which an

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established peer support framework was adapted to add elements specific to resident stressors and CR–resident relationships. One faculty member and two outgoing CRs lead a 2-hour workshop that is built into existing CR onboarding to ensure sustainability. The workshop combines large-group didactics and small-group breakouts, using clinical vignettes and simulated near-peer support conversations. To date, 36 CRs have been trained. CR near-peer support can serve as a model for programs in which true resident peer support is not feasible.

Keywords:
graduate medical education; patient safety, psychological well-being, professional burnout

Involvement in adverse events, medical errors, and difficult patient encounters can take an emotional toll on residents, evoking sadness, shame, guilt, and fear. Left unprocessed, such emotional burden can affect the well-being of residents and can lead to moral distress, burnout, anxiety, and depression (1–3). Support of the trainee to mitigate the harmful effects of such events has not been clearly addressed in residency programs, despite attention from the Accreditation Council of Graduate Medical Education, which includes patient safety event review and error disclosure training as mandatory components of residency programs (4–6). For residents, near-peers—specifically chief residents (CRs) who are close in training to affected residents—may be best suited to provide this vital emotional support.

Peer support initiatives are common for faculty and staff and teach clinicians to provide care for other clinicians experiencing distress from adverse events (7, 8). As structured programs, they train peer supporters in how to provide space for their colleagues to talk about work-related experiences and emotions such as sadness, self-doubt, or isolation through reflective listening, empathetic support, and connection to resources (9). These programs often incorporate outreach to affected clinicians and emphasize matching them with a supporter who is, as much as possible, a peer with an understanding of their experience. Organized programs at several academic medical centers established and shared faculty and staff peer support models for others (10–12). Although evaluations to date have not been able to quantify the impact of these programs on burnout rates or medical errors, these programs have been shown to be desirable by physicians, and studies on outcomes are underway (13–16). A more recent proliferation of similar programs has also been described in the peer-reviewed literature. The interventions vary widely in their design and structure by context (e.g., inpatient, outpatient, coronavirus disease [COVID-19] related), scale, and method of delivery (e.g., group or individual, virtual or in person) (14, 17, 18).

Although many institutions provide peer support programs for faculty, very few programs for trainees have been described in the peer-reviewed literature (19–25). Existing models must be modified before being applied with residents, given that residency is a critical and vulnerable time of personal and professional identity formation that presents unique challenges in identifying appropriate support (26–28). Faculty and program leadership serve as role models and educators but also as

evaluators. These power dynamics and the distance between experiences of faculty and of residents can be barriers to providing effective support (21). Residents may seek support through peers or senior residents, and the peer relationship may be protective against burnout and improve recovery (26, 27). Some institutional peer support programs provide a structure to offer residents support from other residents (25) and from recent graduates (24), describing benefits in normalizing the difficult experiences and allowing emotional and cognitive insight as they promote perceived well-being. However, residents face several barriers in becoming trained peer supporters because they may lack confidence to provide proactive intervention for their peers, and the demands of residency may limit the ability of residents to attend training or dedicate time to supporting coresidents (10, 11, 27). Similarly, organizing recent graduates as trained near-peer supporters faces significant logistical barriers because recent graduates no longer have any formal relationship to the training program and may have limited time and willingness to engage. In this context, CRs can serve a unique and important role as near-peer supporters.

The CR role is typically a 1-year position held by senior or recently graduated residents, and the responsibilities of CRs vary by training program. CRs are in a unique "near-peer" relationship with other residents in the program because they are slightly ahead in training and specifically designated as leaders. CRs have an intimate knowledge of the challenges of training yet enough experience to afford perspective (29), thereby allowing them to address resident anxieties, challenges, and fears from a place of camaraderie, trust, and respect. CRs are often the first to hear of residents' stress and are frequently called upon to provide emotional support (30, 31). They naturally serve in a unique near-peer support role between residents and faculty in many academic residency programs. Although CRs may have an evaluative role for some programs that could hinder them in providing effective support, CRs remain well positioned to understand and empathize with resident stressors, and near-peer inclusion (recent alumni) in residency support groups has been reported to be beneficial. However, to our knowledge, the role of CRs specifically has not been described in any resident peer support or near-peer support programs, and no standardized approach to preparing CRs for this unique role has been published.

NEAR-PEER SUPPORT FRAMEWORK

We adapted a framework for structuring the components of a peer support conversation (10) to add specific elements relevant to the resident–CR near-peer relationship. The framework was developed at the Center for Professionalism and Peer Support at Brigham and Women's Hospital in 2008 and was designed for use by clinicians. It has undergone iterative improvement and has been widely used as a model for programs in the United States and internationally, tailored to local context (10, 32). We used the core concepts of the framework with adaptations for the developmental and emotional position of trainees (e.g., normalizing the feelings of insecurity by sharing that CRs and faculty also make errors) and for their near-peer relationship with CRs (e.g., proactively naming the CR's current role as a supporter, not as an educator). To teach this framework, we developed realistic vignettes to illustrate the principles, and we integrated the training into the existing onboarding process for

CRs within the residency program to ensure its sustainability.

Our adapted framework breaks the components into five distinct stages of a supportive listening encounter, with 12 associated skills (Figure 1). At our institution, one faculty member and two outgoing CRs deliver this training as a 2-hour interactive workshop for all incoming CRs, first introducing the background and framework in large-group didactic format. CRs then break into facilitated small groups to practice simulated near-peer support conversations using three clinical vignettes. Teaching through vignettes and simulation provides opportunities to

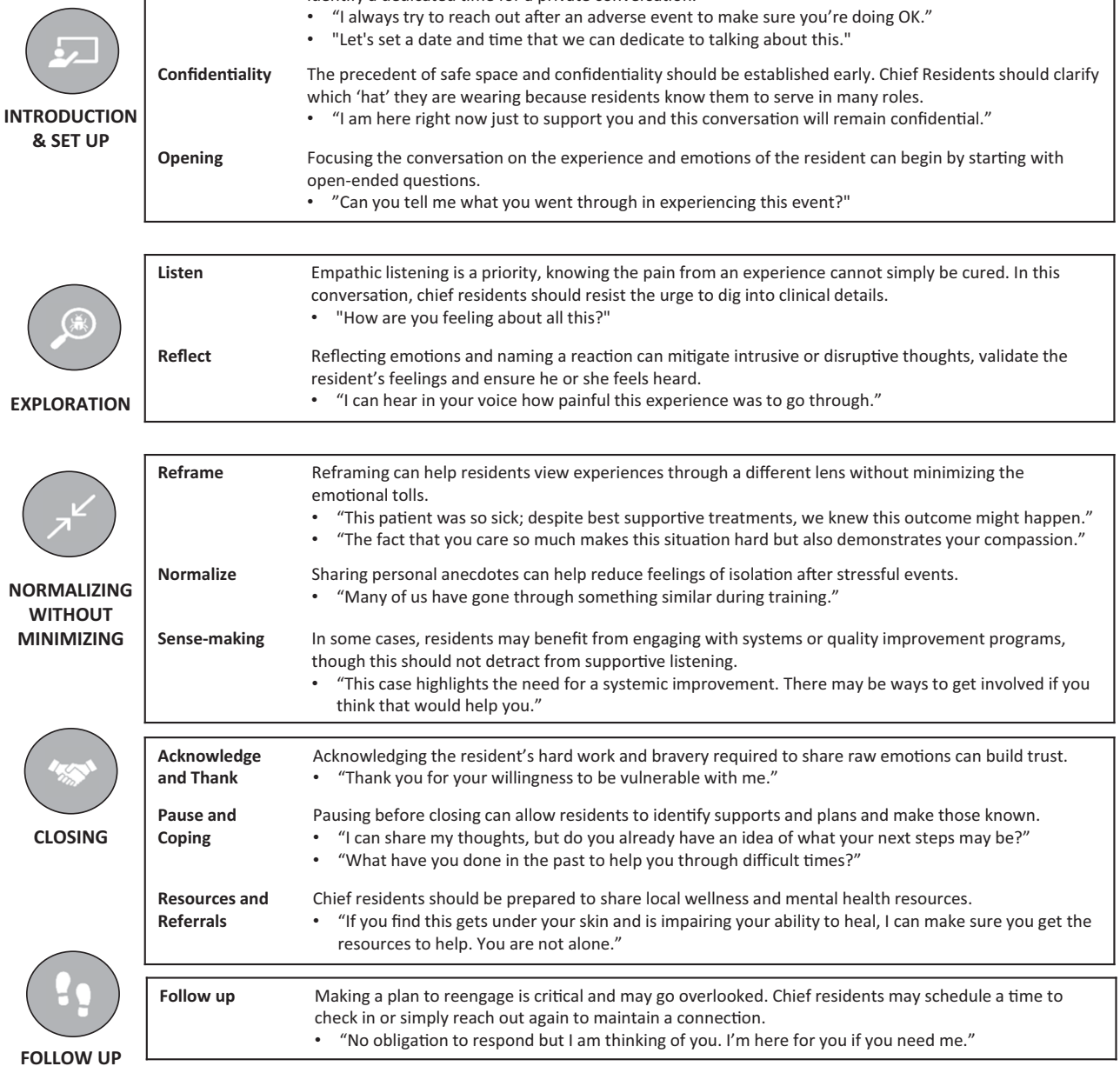

Figure 1. A framework for chief residents to provide supportive listening to residents through five stages of an encounter and 12 skills, with example language. Adapted by permission from Reference 10.

recognize key components of each stage and to practice applying language that suits CRs' individual personalities and preferences. We use multiple vignettes to demonstrate that CRs will encounter a variety of scenarios in which residents may need support, including but not limited to patient safety events. We created facilitator guides and a summary document for participants to reference and consolidate skills. Full training materials are provided as supplemental materials in the data supplement.

CLINICAL VIGNETTES

The three vignettes presented here were designed to provide opportunities for workshop participants to practice applying the framework for supportive listening as a CR. Each encounter can be simulated using the full support framework but were designed to present specific challenges. The first involves a medical error associated with patient harm and focuses on appropriate ways to initiate a supportive conversation after a potentially difficult and traumatic experience for the trainee. The second describes a perceived medical error wherein a resident cares for a patient with an unexpected cardiac arrest and provides the opportunity for a CR to help the resident process many overlapping emotions, including but not limited to patient safety concerns. The third portrays a resident experiencing profound grief unrelated to medical errors after the death of a patient, in which the CR is challenged to support the resident both personally and professionally, particularly in making plans for next steps after their meeting.

Vignette 1: Resident Error

An intern discharges a patient after admission for a pulmonary embolism. Because of a medication reconciliation error, the intern does not prescribe the anticoagulant upon discharge. The team discovers this when the patient is readmitted with another pulmonary embolism.

Outreach to residents about adverse events should be deliberate. We advise CRs to set aside private time and space for the conversation. They should anticipate that residents may react with shock, guilt, shame, or fear. Normalizing the outreach by framing it as routine practice after any adverse event can help.

Confidentiality should be established early in the conversation. CRs need to clarify the specific support "hat" they are wearing, because residents may know them in many roles: a peer, an attending, a leader in the residency program, or a part of quality improvement programs.

Opening with open-ended, nonjudgmental questions should set the focus on the resident's experience and emotions, giving permission to share their perspectives and feelings.

Vignette 2: Unexpected Event

A senior resident is having a challenging week, staying late and feeling exhausted. A patient recently admitted with pneumonia and multiple comorbidities has a pulseless electrical activity arrest. Resuscitation is successful, but the resident is devastated by the event and searches for an oversight or error as the cause.

Listening with empathy is the most important skill in this toolkit, because the resident's pain often cannot be cured. CRs should focus on the resident's emotions and resist the urge to dive into clinical details. Empathic listening may be particularly challenging if a resident is in a defensive mode, so CRs should practice

verbal prompts that both invite discussion and respect different coping strategies.

Reflecting emotions is a way to honor and validate a resident's feelings. CRs should avoid saying they know exactly what the resident is experiencing and instead should empathize with the emotional toll. The act of recognizing and naming the response can help with intrusive reflections such as perseverating on feelings of self-doubt or inadequacy.

Reframing is a technique to put the event in perspective and normalize the event without minimizing the resident's experience. It may be helpful to remind residents if events were unavoidable or inevitable or that all physicians make mistakes. CRs can share personal examples to alleviate a sense of isolation. Reframing pain and guilt as empathy and compassion can help restore personal integrity. We focus primarily on listening separate from problem solving, but, in select cases, residents may benefit from engaging with quality improvement programs to help make sense of adverse events.

Vignette 3: Grieving Loss

A resident is caring for a young patient with high-risk leukemia. Having cared for the patient many times, the resident feels a personal relationship with her. During the current admission, she is transferred to inpatient hospice, where she dies soon after.

Acknowledge and thank the resident for the bravery required to share raw emotions, regardless of whether they relate to adverse events.

Pausing before discussing next steps can allow residents to identify support systems and plans and make those known to the CR.

Coping strategies are unique, so eliciting residents' techniques is a way to support and motivate while turning the conversation toward the future. This step can also be used to engage their personal support structures outside of the residency program.

Resources and referrals are important for residents who may benefit from professional support. Chaplains or counselors, for example, may be necessary for only a small proportion of residents, but CRs should offer local wellness and mental health resources to everyone.

Follow-up is critical and easily overlooked. CRs should share contact information and make a specific plan to reengage. They can identify a concrete time to follow up (e.g., 1 wk) or send a text message or e-mail 1–2 days later to simply connect and reaffirm that the resident is not alone.

CONCLUSION

Peer support for physicians who experience adverse events is an important but often-overlooked aspect of patient safety, because moral distress from the event can directly affect physician well-being, especially in residency. Although resident peer support programs exist, there are barriers to widespread implementation, including resident time constraints for receiving training and providing support. When programs face such barriers, CRs providing near-peer support can be an effective alternative. CRs are uniquely positioned to mitigate the effects of difficult experiences on resident well-being and are already asked to do so without specific skills beyond those acquired organically through recent lived experience. Providing near-peer support training in their orientation process can help prepare them for this role, better enabling them to support residents through the stressors of a vulnerable period of personal and professional identity formation. We introduce a near-peer support framework

and teaching materials to facilitate this training. To date, 36 CRs have participated in the workshop described here at one internal medicine residency program. Limitations of this program include a lack of objective outcome measures either for the CRs as learners gaining competence or in measures of resident well-being, which should be the focus of future work.

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