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How Peer Support Enables a More Sustainable Professional Medical Role: A Qualitative Study

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Abstract

Peer support services have been established in several professions to help individuals cope with challenging work and life situations. Using the medical profession as an example, we have qualitatively studied physicians' experiences of peer support. We conducted interviews with 12 physicians shortly after they had attended peer support and 12 months later. We analysed the interviews using systematic text condensation. We then reanalysed each pair of interviews (baseline and follow-up) using Schein's model to further deepen the analytical insights. The results show that the professional medical role can evolve. Peer support helped the individual physician to become aware of, acknowledge and adjust to how unwritten rules within the medical culture had formed a non-sustainable professional role. Peer support can facilitate changes at and outside work, as well as foster a willingness to seek treatment for self-care.

Keywords

Physician distress, professional distress, medical role, medical culture, peer support, qualitative, professional role, sustainable physician role

Introduction

The work in many professions implies meeting inherent and specific challenges related to professional norms and work environments, which can threaten their members' sustainable health and well-being. Thus, understanding and dealing with professional experiences are important for mitigating the risks of work-related stress and its consequences. To address these issues, peer support programmes have been established for different professions (Isaksson Rø & Aasland, 2016; Milliard, 2020; Sarros & Sarros, 1992). A peer supporter has the same basic professional education as the person seeking help and is, therefore, familiar with that person's work environment (Abrams, 2017; Isaksson Rø & Aasland, 2016). The benefits of peer support services for enhancing mental health and well-being are progressively gaining recognition (Lewis et al., 2020). Peer support services provide low-threshold support, with or without training for peer supporters, and a range of approaches are considered good practices (Khan & Vinson, 2020; Miguel et al., 2023). Studies have shown that physicians seek peer support for a wide range of reasons and that most find it beneficial (Abrams, 2017; Horne et al., 2021, 2023; Isaksson Rø et al., 2010), but knowledge is nevertheless lacking regarding how and why peer support helps professionals. An in-depth study of an archetypal profession, such as medicine (Freidson, 1970), could provide such knowledge while simultaneously being relevant to other professions.

Since the mid-1980s, studies have revealed high levels of physician burnout (Hiver et al., 2022), with consequences for individual physicians and the quality of patient care (Scheepers et al., 2015). Physician distress has largely been attributed to high expectations of individual performance, combined with an ethos in the medical professional culture of putting patients´ needs first, as well as the expectation that physicians should exhibit altruism, self-sacrifice, perfectionism, and conscientiousness (Collier, 2012). Medicine, like many other professions, has developed a unique culture characterised by strong socialisation during the education and training period, which transmits learned values that are preserved in the profession (Ginor & Becker, 2017). This professional culture fosters a sense of group belonging in medicine, which promotes high professional standards for patient care (Freidson, 1988). However, elements of the culture are also associated with a tendency to overwork and a perception that normal human limitations (sleeping, eating, being sick, etc.) do not apply to physicians since they are expected to "be immune to illness" (Fox et al., 2009, p.817). The professional values that increase the risk of overworking align with traits already prevalent in students admitted to medical schools—neuroticism and conscientiousness (Collier, 2012; van der Wal et al., 2016). They are also transmitted in educational and training settings by senior physi-

cians who continue to work despite being sick and do not allow themselves to react emotionally or take their own needs seriously (Torralba et al., 2020). This nonverbal transmission is called the "hidden curriculum" (Bennett et al., 2004, p.145), and it emphasises meeting professional demands and deprioritising self-care and personal relationships (Shanafelt et al., 2019). The lack of acknowledgement of these issues at the professional level can lead to physicians engaging in potentially destructive behaviour regarding their own health and well-being (Shanafelt et al., 2019).

Seeking support or admitting to needing help may often seem difficult or threatening because there is a risk of appearing weak, incompetent, or vulnerable (Gray et al., 2020), generating feelings of shame and embarrassment among physicians (Brooks et al., 2011). To lower the threshold for seeking help, peer support services for physicians have been developed in several countries, such as Denmark (Lægeforeningen, 2023), Great Britain (BMA, 2024; Shapiro et al., 2014), and the United States (Stanford Medicine, 2024). Peer support differs from treatment in offering collegial, confidential discussions, and it is therefore perceived as less evaluative (Zee & Bolger, 2019). Studies of physicians have shown that self-care and treatment-seeking (Abrams, 2017; Horne et al., 2023; Isaksson Rø et al., 2008) reduce levels of burnout, job stress, depressive symptoms, and anxiety for up to three years after subjects receive peer support (Isaksson Rø et al., 2008, 2010). To study how peer support can facilitate such changes, we used a model developed by Schein (2017) describing relationships between workplace organisation and organisational or professional culture (Schein, 2017). Some parts of a culture may act as barriers to change, although professionals' individual understanding of cultural values can be promoted to reduce or remove such barriers (Schein, 2017). Schein´s (2017) framework has been used to consider the medical profession's culture in relation to burnout and well-being (Shanafelt et al., 2019). Schein described elements of professional culture as unwritten rules (basic underlying taken-for-granted assumptions) that drive behaviour and are often so integrated into the culture that they are considered nondebatable—"cultural DNA" (Schein, 2017, p.7; Shanafelt et al., 2019). They are hard to see and even harder to change, but they can be revealed by studying discrepancies between what we say (which Schein (2017) called our espoused values) and what we do (which he referred to as artefacts). Gaining awareness of and acknowledging such discrepancies can enable individual professionals to question established perceptions and practices, which can facilitate changes in their values and, thus, in their behaviour.

In 1998, a peer support service, Villa Sana, was established for all physicians in Norway to "enhance health and life quality, strengthen professional awareness and identity and prevent burnout" (Modum Bad, 2023). A study of physicians who engaged with this peer support service reported various reasons for seeking support, from worries that the work situation over time would be too exhausting to serious symptoms of mental and somatic illness (Horne et al., 2021). Common to all physicians seeking help was the fear that acknowledging their own need for change, sick leave, or treatment would be perceived as professional weakness and

disloyalty to colleagues and patients. In this study, one year later, we reinterviewed the same physicians who had attended the peer support service to explore whether and how they perceived peer support as a means of fostering more sustainable physician roles, particularly in relation to self-care.

Aim

The aim of our study was to investigate how peer support can facilitate a more sustainable medical professional role and promote self-care.

Methods

We conducted semi-structured interviews with physicians shortly after they sought peer support and one year later. This enabled us to investigate beliefs, values, and changes over time, allowing us to explore the meanings of social phenomena as experienced by the individuals themselves (Malterud, 2017; Patton, 2014).

The National Peer Support Service, Villa Sana

We recruited physicians who had received peer support from the Norwegian national peer support service at Villa Sana (Modum Bad). This confidential counselling setting does not involve formal medical treatment or medical records for either a single-day one-to-one session (duration 6 hours) or a five-day on-site course. The one-to-one sessions provide an opportunity to identify areas of physicians' lives that require attention and modification. The handling of situations and the prioritisation of different needs are discussed in terms of the conditions that can hinder or facilitate necessary change. The courses accommodate nine physicians and include daily lectures about preventing burnout, opportunities, and restraints in working life, as well as professional identity. Furthermore, the courses help attendees practise mindfulness and physical activity, and attendees are offered individual peer counselling sessions. The counsellors are mostly physicians, but they also include some experienced psychologists. From a previous study (Isaksson Rø et al., 2010), we know that there are no significant differences in outcomes between doctors attending one-day counselling sessions or week-long courses.

Participants and sampling

Thirteen physicians attending the peer support service were interviewed in 2018. Twelve of them, seven who had attended the one-day session and five the course, were re-interviewed one year later. One withdrew from the study. This article is based on a longitudinal qualitative approach and analyses of the two sets of interviews (Audulv et al., 2022; Hermanowicz, 2013). We recruited eight women and four men, aged 25–70 years old, from diverse medical specialities (family medicine, surgical specialities, laboratory medicine, psychiatry, and internal medicine) and from different parts of Norway to ensure high information power (Malterud et al., 2016; see Table 1).

Table 1

Demographic Data 2019

Selected Participants' Characteristics (n = 12)	Participants (n)
Gender	
Male	4
Female	8
Age (average 46 years)	
20–30	1
30–40	4
40–50	2
50–60	2
60–75	3
Medical Speciality	
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

In the baseline semi-structured interviews conducted in 2018 (1–1½ hours each), shortly after they attended the peer support service, we explored why the physicians sought peer support (Horne et al., 2021). To explore what they had done to improve their situations, we conducted follow-up interviews (1–1½ hours each) one year later (± 30 days). Based on a qualitative longitudinal approach, we gathered data at multiple time points, focusing on changes in phenomena over time (Audulv et al., 2022). The participants signed written informed consent forms before each interview. The first and last authors conducted the interviews. Interviews were audiotaped and transcribed verbatim and complemented with notes taken during the interviews to aid in the discussion of perspectives and interpretations after each interview.

Data analysis

We analysed the follow-up interview transcripts using systematic text condensation (Malterud, 2017) to study how the participants had handled their situations in the year following peer support. Systematic text condensation involves four basic steps to achieve a descriptive and explorative analysis of data: 1) reading through the material to obtain an overall impression (i.e. moving from chaos to themes), 2) identifying and sorting meaning units (i.e. moving from themes to codes), 3) condensation (i.e. moving from codes to meaning), and 4)

synthesising (i.e. condensation to descriptions and concepts; Malterud, 2017). At least two authors read all the interview transcripts. The first and last authors, in parallel, analysed two follow-up interviews and discussed codes until they reached consensus. The first author then used the codes to analyse the remaining interviews. All four authors helped synthesise the results. To examine the participants' behaviour, mindsets, and values, we reanalysed both interview transcripts for each participant. We applied Schein´s framework as a theoretical lens to understand the associations between the changes reported by the participants and changes in the expectations of the professional role by examining statements regarding values in the medical culture that the participants made during the two interviews.

Results

In the results section, we present the participants' perceived importance of the peer support setting for fostering change, the changes they reported having made (artefacts) in their work situations and outside them, and the benefits of seeking treatment. In the following paragraphs, we illustrate the changes in the participants' perceptions regarding their professional medical roles and related self-care. Table 2 presents each interviewee's views on the importance of peer support for fostering change, the changes they reported, and key quotes reflecting their professional medical values in 2018 and 2019.

Table 2

Results

No.	Year	The Role of Peer Support (Quotation)	Reported Changes (Artefacts)	Year	Quotation	Espoused Value
1	2019	"*Taking responsibility for my own work health and actually attending this course—almost as if legitimising, both for myself and outwardly, that this is something I need—gave me a kind of platform to move forward.*"	Has obtained a new position with reduced working hours [part-time sick leave] and without direct patient contact. Attended psychotherapy. Engaged in continuing medical education. Has more contact with family, Prioritises physical activity.	2018	*"There is a feeling of shame because you actually drop out of working life and cannot tolerate stress. We are highly educated; we ought to know for ourselves what we can or cannot tolerate …. and what we should do about it."*	I must understand myself and what I can and cannot tolerate. I have nothing to complain about.
				2019	*"What was interesting was receiving confirmation of the seriousness of the matter—that I did the right thing by asking for help and that help was available."* *"I am allowed to say that I am human."*	I think it is right for me as a doctor and human to ask for help.

Table 2 (Continued)

No.			Artifact	Year	Quotation	Espoused Value
2	2019	*"I didn't get what I expected. Of course, it was an important part of my journey—knowing that even when I felt completely alone, somewhere in Norway, there was someone who had some of the same thoughts."*	Back at work, exempt from on-call work for a limited period. Now receives regular follow-up for a somatic illness. Attends psychotherapy.	2018	*"You have a duty to work. … So, I have not identified myself with any of my diagnoses."* *"I feel shame about getting sick—a strong feeling of guilt about the fact that I am out of work and experiencing grief related to my loss* of *identity, role, and career. I am no longer the super doctor that you are expected to be."*	As a doctor, I have a duty to work, no matter what.
				2019	*"I now feel that I see life and work differently, and I have plans to reduce my working hours to a 100% position."* *"Why do I feel like shit when I only work 100%? But that's how the medical profession is defined in a way; you are not 100% when you are 100%—you are 100% when you are 140% or something."* *"I really want to follow the Working Environment Act."*	It is the right thing to do, to take care of myself.
3	2019	*"Yes, it matters. It felt really good to have a place to go—it was the beginning of something."*	In the same position (a full-time job). Attends psychotherapy Receives compensation for overtime work and has postponed senior medical leave. Has opted for early retirement.	2018	*"If something is problematic, I assume that I'm to blame, and if it feels too difficult, then it's me who has to work harder, or something like that."*	It is my fault that I am treated the way I am at work, and the solution is to work even harder.
				2019	*"There is a workplace culture, you could almost say a distinctive feature of the profession, that expects most of us to … be able to work constantly at our tolerance limit."* *"I told them straight out that this hospital had ruined my health."*	There is nothing wrong with me—something is wrong with the workplace culture.

Table 2 (Continued)

No.			Artifact	Year	Quotation	Espoused Value
4	2019	*"I think it [peer support] started a chain of thoughts … that I shouldn't resign myself to enduring another year or five more years."* *"I think maybe it gave me a little push to do something."*	Same working conditions. Attends psychotherapy. Has made an appointment with the Family Welfare Office and a general practitioner [for the first time]. Took short-term sick leave.	2018	*"I have virtually no social life. I come home from work so that I can put the kids to bed, and then I'm completely exhausted. There is not much I say 'yes' to [socially], but at work I cannot say 'no'."*	I have to put up with the job and endure it.
				2019	*"I have been telling myself for many years now, 'It will probably get better by itself.' I think that it [peer support] was at least the start [of a different way of acting]."*	If I want change, I must act on it.
5	2019	*"It was a very helpful day at Villa Sana."* *"I had many 'aha!' moments that day about why I react the way I do."*	On maternity leave and returns to a 100% position when it ends.	2018	*"I demand a lot of myself. When I go around, I'm afraid of making mistakes and … of simply not being good enough."* *"Somehow, I have to perform well on every level."*	I must not make mistakes.
				2019	*"The requirements one feels and the fear of making mistakes… are perhaps special for this profession."*	I must not make mistakes.
6	2019	*"Just being there with the others [at the peer support service], talking to them and being in a setting where everyone had their stuff [difficulties], felt like a sanctuary where you could be yourself."* *"It helped, almost like a weight was lifted when I arrived home. It was important for me and made me more aware of what I struggle with, so that's a positive thing."*	Started a new medical specialty after a long period of sick leave.	2018	*"It's okay to have flu, but I should not be sick in the way I am now. When I hear myself saying that, I realise it's harsh, but that's how I feel."*	Having a mental illness is not compatible with the doctor's role.
				2019	*"With everything I've been through, I feel that I'm a little less concerned with the facade and with hiding things, so it feels a little better."*	I can be a doctor even if I suffer from a mental illness.

Table 2 (Continued)

No.			Artifact	Year	Quotation	Espoused Value
7	2019	*"I think the conversation [during peer support] came at a good time, when I was receptive to finding solutions and thinking about the way forward, and I believe I have used the input I received from the peer supporter."*	Works part time (50%). Has initiated regular exercise. Attends a metacognitive therapy course.	2018	*"I take personal responsibility until I become so … ill [mentally] that I have to give up."* *"There is less stigma … about going to a somatic doctor than to a psychiatrist."*	As a doctor, I should take responsibility for treating my own mental illness.
				2019	*"Actually, it is fairly obvious that I should work less, but … to realise it and then accept it and sort of lower my expectations … it takes some time."* *"Even though [physical activity] is not psychotherapy, it works as mental therapy all the same. I feel that I benefit from it."*	It is important for me to prioritise what I need and accept treatment when necessary.
8	2019	*"So, we talked about these things, and she [the peer supporter] was the one who recommended that I talk with the municipality [the employer], be honest, and say what I meant. Not long after that, I brought it up with the municipality. Maybe I needed someone to tell me that it was okay to speak up."* *"I simply gained the confidence to trust myself a lot more. I think it helped a lot."*	Has gained control over alcohol consumption. Has relocated and started working in a new specialty.	2018	*"It became easy to resort to alcohol when there was not much else to do. Then, I began experiencing a high level of stress at work and started losing control."* *"It's a bit stigmatising [seeking help], and I do not want a patient record."*	I cannot ask for help due to my alcohol problems.
				2019	*In relation to alcohol, complete abstinence was not necessary, but the therapist [peer supporter] suggested [abstaining for a while], and I decided to try it."* *"I think, in summary, I probably gained more confidence."*	I can and should ask for help when I need it.

Table 2 (Continued)

No.			Artifact	Year	Quotation	Espoused Value
9	2019	*"It was quite good, and it helped a lot. It really did."* *"It was really useful for me to talk and let it all out."*	Now works four days a week. Attended a mindfulness course. Attended psychotherapy. Has told several colleagues about the situation.	2018	*"I felt like a patient and … I felt completely emptied of medical knowledge."* *"As a doctor, I worked for far too long [before seeking help]. It is embarrassing because we are trained [to identify diseases."*	It is not possible to tell anyone that I am ill; as a doctor, I should know how to avoid mental illness.
				2019	*"We did not feel like doctors when we were there [on the peer support course]. We felt like patients."* *"I think the important thing was to get away from all my daily routines [by attending the course] ... It was relaxing, but at the same time, we had to face the reality of what we go through every day. So, in a way, we could see our lives from the outside when we were there."*	For me, as a doctor, it is acceptable to become sick and to talk to others about it.
10	2019	*"I feel like it untangled a knot."* *"I managed to get past that low point without it becoming more serious, and in those conversations, I was able to see more clearly what I was struggling with."*	Work and private situation unchanged.	2018	*"I actually felt that I was the one who managed to cope with everything."* *"It is always a struggle against a guilty conscience when you leave home early and come home late."*	I should always prioritise work.
				2019	*"I think it makes sense for me … to somehow strengthen [prioritise] myself and find a strategy for going forward. I've been thinking that I should find someone to talk to."*	It is not obvious that I should prioritise work.

Table 2 (Continued)

11	2019	*"I learned words and concepts for things that hadn't been clear to me before. … I think they will be very useful for the rest of my life."*	Works only in a clinical setting. Receives support from the occupational health service. Attends psychotherapy. Initiated regular exercising. Allocates days without scheduled activities as breathing spaces.	2018	*"I even told my residents, 'You have chosen a lifestyle.' … I belong to the generation that thinks it is a way of life, but not all resident doctors think that way."*	I chose the lifestyle that goes with being a doctor.
				2019	*"After being at your place [peer support] I was not certain that the residents agreed with me at all. I felt that it was completely natural for them … that this was a job. I believe that in healthcare, we can't have people thinking it [working as a physician] is a normal job, but I understand that it's not healthy … that it shouldn't occupy as much [of life] as I allowed it to do before, or as many doctors did before me and several doctors do today."*	I think it is unhealthy for life to be only work.
12	2019	*"It was useful to put things into words with another person present … someone who wasn't a partner or a friend or anything like that. I think many doctors could benefit from that."* *"I think it is quite important for the person sitting there to be … someone who understands, in a way, what it's like."*	Works as a researcher. Seems to be embracing a more diverse physician identity.	2018	*"You are told every day that the only important work you can do is there [in a patient-related role]. Everything else is useless. The peak of happiness, workwise, it's where it happens; it's where you are important."* *"I kind of think I am not good enough at anything. I think no one has a use for my work … and working life has no use for me."*	I should work with patients to be valuable and succeed at work as a doctor.
				2019	*"I have worked on a collaborative project to improve clinical research."* *"My colleagues are very skilled people and a fun team to work with, so I was drawn in."*	I can contribute with something important and valuable by doing nonclinical work.

Perceived importance of peer support for subsequent change

The interviews revealed that the physicians considered participation in the peer support programme key to facilitating reflection on and subsequent changes in the difficult situations they faced:

(i) The results showed that peer support can legitimise help-seeking and emphasise the importance of taking one's condition seriously. As Interviewee 1 (2019) stated, "What was interesting was obtaining confirmation of the seriousness of the matter—that I did the right thing by asking for help and that help was available. I am allowed to say that I am human."

(ii) The participants claimed that the realisation that colleagues also struggled with the gap between their needs and their role expectations was a step towards accepting that change was necessary. Interviewee 6 (2019) stated, "Just being there with the others [at the peer support service], talking to colleagues and being in a setting where everyone had their stuff [their difficulties], felt like a sanctuary where you could be yourself."

(iii) The participants found that peer support contributed to a better understanding of their own reactions, promoted an awareness of physicians' difficulties, and gave them words and concepts to help clarify their situations. Interviewee 11 (2019) explained, "I learned words and concepts for things that hadn't been clear to me before. [...] I think they will be very useful for the rest of my life."

(iv) The participants experienced the peer support sessions as a push towards doing something constructive rather than hoping that the situations would change automatically. They also described experiencing increasing trust in themselves and emphasised that it was important for "the person sitting there [the peer supporter] to be […] someone who understands, in a way, what it's like" (Interviewee 12, 2019).

Making changes in the work situation

(i) Reducing the workload. The participants saw reducing the workload as beneficial. They achieved short-term reductions through spells of sick leave or by spreading their days of annual leave or sabbaticals across weeks. In the long term, they found it beneficial to reduce their work to part-time or to reduce their workloads by changing work tasks, such as switching to nonclinical work for a period, working less with patients and more to support younger colleagues, or being relieved of educational tasks. Interviewee 10 (2019) described replacing 50% leadership–50% clinical work with work in a 100% clinical position:

> Now I work 100% in a clinical setting. [...] When you work like that (clinically) […] you don't have to take your work home with you, but when I worked as a manager [...] most weekends, I would get a phone call about something that had happened or someone who had called in sick […] I had to work all the time. It's a huge difference.

Some participants moved to new work positions with more collegial collaboration, and two participants shifted to a new medical speciality.

(ii) Changes in approaches to work. The participants reported changing their approaches to work as a way of improving their situations. Increased self-confidence helped them dare to

raise issues with their managers, which alleviated the situations, or they dared to stand up to senior colleagues. According to Interviewee 8 (2019):

> I've become much better at handling things. Whenever I need to consult with […] an on-call doctor[…] and they start getting a bit rude, I don't put up with it. I've become very good at telling them that I don't want to listen to that sort of language. I'm not calling them for fun; I'm calling because I need assistance.

Some participants found it inspiring to assume professional responsibility for a specific area of clinical work. Others reported deliberately slowing down their pace at work to allow them more time to speak to patients.

Changes in situations outside work

(i) Addressing private relationships. Four participants reported recognising and accepting the need to readjust their relationships with their partners and children by, for example, prioritising home life and communication with their partners. Interviewee 1 (2019) said:

> What hasn't changed? [...] How much I expect to do in a day, both on my own behalf and with the kids, uh, how I talk to my children [...] We talk a lot more about feelings and priorities in life. That's important to them.

Two participants had started the process of separating from their partner after peer counselling.

(ii) Alterations in daily routines. The participants perceived changes in their daily routines, such as increasing physical activity, as beneficial for physical and mental health. Interviewee 7 (2019) explained, "Even though it [physical activity] is not psychotherapy, it works as mental therapy all the same. I feel that I benefit from it, so it's well worth the money and time invested."

Other beneficial initiatives included practising mindfulness, engaging a cleaner at home, dedicating days to doing nothing, reading books about stress management, keeping diaries, and reducing the use of alcohol.

Seeking treatment

Half of the participants sought psychiatric or somatic treatment after peer counselling. They found that validation of the need for treatment by peer counsellors and the healthcare system was important for normalising their situations.

(i) Therapy helped reduce depressive symptoms, anxiety, and sleep disturbances, and it also facilitated returns to work, in some instances, albeit while taking antidepressants and hypnotics. Interviewee 5 (2019) explained:

> Since then, I have attended therapy with an experienced psychologist. I still do. I was on sick leave for a fortnight. I took sleeping pills and began to sleep again. Since then, I've been back at work. I must say that I have benefitted from psychotherapy. I feel better than I did a year ago.

Some participants found couple´s therapy important for their relationships with their partners and children.

(ii) Somatic treatment. After years of denying their conditions, two of the participants sought necessary somatic treatment from healthcare providers after receiving peer support. Interviewee 1 (2019) said, "I learned a lot on a human level about the fact that I actually have a chronic illness and about all the challenges that I have neglected in my daily life."

Changed perceptions of the professional medical role

When seeking peer support, some participants described feeling trapped in a situation in which their challenges (feeling mentally or physically ill or not coping with their work or work–home balance) did not match their expectations of what a good physician ought to be (Horne et al., 2021). They expressed impatience and devalued their own reactions, feeling that they should cope in a more "professional" way. Interviewee 2 (2018) said, "You have a duty to work and to sort of keep on going. […] You have a social responsibility, and you should get a grip and somehow give it your best," and Interviewee 6 (2018) said, "I should not be sick in the way I am now [mental illness]. That´s not the way it should be."

At the follow-up, some participants described changes in their own role expectations regarding how to cope with being a physician, having become aware of the discrepancy between the situations they faced and their baseline role expectations. They were more accepting of the importance of self-care, seeing that it could be unhealthy for life to consist only of work and that you could be a good doctor while at the same time having an illness that required treatment. (See Table 2 for descriptions of individual changes from baseline to follow-up.) Interviewee 2 (2019) made the following comment:

> I now feel that I see life and work differently, and I have plans to reduce my hours by taking a 100% position. […] Why do I feel like shit when I only work 100%? But that's how the medical profession is defined in a way; you are not 100% when you are 100%—you are 100% when you are 140% or something.

Interviewee 6 (2019) said, "With everything I've been through, I feel that I'm a little less concerned with the facade with hiding things, so it feels a little better," and Interviewee 11 (2019) elucidated:

> We can't have people thinking it [working as a physician] is a normal job, but I understand that it's not healthy […] that it shouldn't occupy as much [of life] as I allowed it to do before, or as many doctors did before me and several doctors do today.

Discussion

In this study, we investigated how professionals perceived peer support that enabled them to reconsider their own expectations of the role of physician, practise better self-care, and thereby define more sustainable work situations.

At baseline, the physicians reported experiences of not coping with their situations due to illness or challenging work situations—including work-life imbalances (Horne et al., 2021). They also assumed that their professional medical roles involved having a duty to work, no matter what, or that having an illness was incompatible with being a doctor. Their actions align with a culture that can harm individuals who adhere to professional, often nonexplicit, norms that are considered correct (Bennett et al., 2004). According to Schein´s (2017) organisational theory, this results in as a discrepancy between physicians' experiences of needing help and treatment (artefacts) and the professional medical culture's belief that "a doctors´ duty is to work, no matter what" (espoused value). In the peer support setting, the physicians increased their awareness of this discrepancy, which enhanced their acknowledgement of their situations and prompted reflection on alternative ways to achieve change.

At the one-year follow-up, the physicians reported changes in their understanding of their professional medical roles. The participants highlighted the importance of taking care of oneself (although this could be difficult), seeing that it can be unhealthy for life to consist only of work, and embracing the idea that a good doctor heeds his or her own needs (espoused values). This change in expectations of the medical role seemed to have facilitated the changes reported at follow-up—at work, outside work, and through treatment seeking (artefacts). This reduced the gap between artefacts and espoused values (Schein, 2017), enabling the professional medical role to evolve. The expectations and values implying that doctors need to work, no matter what, or cannot be mentally or physically ill point to an unwritten rule: "Doctors should be able to endure anything." This unwritten rule reflects integrated socialisation into a professional culture, as if "nature really works this way" (Schein, 2017, p.21), and learning something new in this realm requires us to "re-examine, and possibly change, some of the more stable portions of our cognitive structure" (p. 22). The physicians who participated in this study sought peer support because they needed guidance, change, and improvement in their lives (Horne et al., 2021). Although there was great variation regarding the specifics of why the physicians sought peer support, they all seemed to experience peer support as a unique window of opportunity for better understanding their own situations and making necessary life and work changes. They shared feelings of struggling to cope and falling short of their professional values, and they perceived the benefits of the peer support programme (Horne et al., 2023; Isaksson Rø et al., 2008). The physicians reported that they discovered new avenues for action through peer support and subsequently became better positioned to do something about their difficult situations. They shifted from ignoring or dismissing their own physical and mental needs to a greater acceptance of their situations, recognising that

factors such as illness, personal limitations, and self-worth beyond work performance influenced their medical roles (Shanafelt et al., 2019). They became aware of the implicit, almost unconscious values that Schein called "taken-for-granted assumptions," which can be questioned and altered, allowing for new choices that lead to improved self-care (Schein, 2017, p.7).

Can individual changes affect the general understanding of the professional medical role? First, collegial discussions of challenges and experiences within counselling settings can facilitate the spread of new thoughts and ideas across the wider professional community. Second, participants can take their new ways of thinking back to their workplaces by, for example, challenging established norms about what is acceptable and through new ways of doing things. One of the study participants no longer accepted that senior doctors on call should not be disturbed, leaving junior doctors to manage everything alone. This junior doctor started to demand support more clearly, which had implications for the medical role as well as for colleagues and leaders. Third, counsellors can use their counselling experiences when teaching medical students and young physicians, which can pave the way for new values and norms among a new generation of doctors. Changes facilitated at an individual level through peer counselling can potentially affect the established medical culture. Nielsen et al. (1995) stated that "for real long-term organisational change to occur, the systems existing within the minds of individuals must be altered" (p.35). Future researchers must examine possible relationships between individual changes and changes in elements of the professional medical culture, as well as in the wider professional work culture.

The physicians in this study described the peer support service as important for enabling them to change their situations. The service provided a setting in which the physicians discovered (often to their surprise) that they were not alone in their struggles. This legitimised their experiences of being in difficult situations and raised their awareness of ways to do something about them. The physicians described developing a clearer understanding of their struggles and learning to identify and categorise them. They also received gentle prompts to make changes at work or to seek treatment rather than passively waiting for their situations to improve.

The need to change values and, consequently, behaviour can be challenging in an established professional medical role. Such basic changes can represent a threat to individuals' self-esteem and professional and social acceptance within a professional culture (Alicke et al., 2020), and change can be a profound process that takes time (Jacobs et al., 1998). Peer support can reduce such threats by normalising the struggle to become a good professional (Jacobs et al., 1998). The realisation that other colleagues share the same struggle can minimise experiences of vulnerability and social stigma (Abrams, 2017) by mitigating the shame, embarrassment, and loneliness many physicians feel when seeking help (Brooks et al., 2011). This acknowledgement manifested in the interviews in the physicians' descriptions at follow-up of how they managed their situations differently, reporting changes (artefacts) that now

aligned better with their new espoused values (Schein et al., 2017). These changes included reducing their workloads through sick or sabbatical leave, individually adapting their work situations to meet specific needs, seeking somatic or psychiatric treatment, engaging in physical activity, and striving for a better work-life balance.

Strengths and limitations

This study contributes to a growing body of research on unhealthy professional cultural values that need to be changed to promote better self-care. The medical profession has been described as an archetypal profession, and the results of this study provide important insights for other professions for which peer support is established. A possible limitation to the interpretation of the results is the substantial variation in the reasons for the physicians in this study seeking peer support. Despite these differences, they described shared challenges in setting boundaries and taking care of themselves within a medical culture that expects physicians to be competent in all areas of life.

Although most of the peer supporters at Villa Sana are physicians with backgrounds in psychiatry, some of them are psychologists. This could be a limitation of the study because of differences in professional education and work experience.

Although qualitative studies can yield rich material from only a few interviews (Patton, 2014), and the sampling of participants ensured variation in terms of medical speciality, age, gender, and place of work, the small number of participants (N = 12) inevitably limits the external generalisability of the results.

A multidisciplinary author group, including two physicians working for the peer support service and two from other academic backgrounds studying medical professionalism, leadership, and organisational change, broadened the interpretation and understanding of the empirical material (Patton, 2014). We acknowledged the researchers' diverse influences in discussions when identifying and interpreting topics, which involved the researchers reflecting on their own professional values (Kvale et al., 2015). By approaching the material using a well-known theoretical lens that has already been applied to the field of medical professionalism, we are helping "the field build up a coherent body of work, which is transferable beyond the conditions in which individual studies were conducted," according to Bolander Laksov's work on making theory explicit (Bolander Laksov et al., 2017, p.2). This study can, therefore, be relevant and useful for physicians and other professions that offer peer support.

Conclusion

In this study, we explored how peer support can contribute to evolving the medical professional role and fostering improved self-care practices. The physician participants expressed new or increasing awareness of the discrepancy between their situations, involving difficult life and health situations, and the expectations within the medical professional culture that they should manage work, no matter what. A year later, the expectations of the medical role

had changed towards acceptance and acknowledgement of the medical role as also including factors such as illness, limitations, and self-worth beyond work performance. This helped the physicians move towards more sustainable physician roles, allowing for self-care, handling their situations by seeking treatment, or making changes within or outside of the workplace. Realising that other colleagues shared the same struggles provided relief by reducing feelings of vulnerability and social stigma.

Peer support offers an arena for enhancing awareness, acceptance, and acknowledgement of opportunities and alternative ways of understanding the professional medical role, which can lead to better self-care. These findings may apply to other professions; however, further research is needed to explore how peer support can foster a healthy professional culture and role identities that support self-care.

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