



**Experiences of implementing a peer support
programme for surgeons after adverse events**

Miss Gemma Scrimgeour

Specialist Registrar in Urological Surgery

Faculty of Science and Technology

Bournemouth University

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“Every surgeon carries about him a little cemetery, in which from time to time he goes to pray, a cemetery of bitterness and regret, of which he seeks the reason for certain of his failures.”

René Leriche (1879-1955)

Abstract

Introduction:

Surgeons are profoundly affected after adverse events (AEs). Evidence suggests that surgeons want to talk in the aftermath but often speak to no-one after an AE. Furthermore, surgeons do not engage with existing support mechanisms and have been described as a “minority within a minority” in this regard. While surgeon-specific peer support programmes can be effective, only two published programmes currently exist, both of which are in the USA. In light of this, the Surgeon Peer-led Post-incident Response Teams (SUPPORT) Improvement Collaborative was launched in January 2024 to address this gap in providing peer support for surgeons following AEs in the UK. Given the lack of in-depth research focused on experiences of implementation of support programmes for surgeons, this study aims to understand surgeons’ experiences of implementing the SUPPORT programme, and specifically to qualitatively explore the barriers and facilitators to successful introduction.

Methods:

A total of 12 UK and Irish Trusts enrolled in the SUPPORT project, from which 55 individuals participated and set up 'site teams' at their respective organisations. In-depth semi-structured interviews were carried out online with clinicians who were part of the SUPPORT site teams. A total of 16 site team members, most of whom were surgeons, completed a semi-structured interview between January-April 2025. The interviews explored experiences of implementing the project including barriers and facilitators to the initiative, experiences of providing peer support to surgeons after adverse events and the potential impact of the SUPPORT collaborative. Reflexive thematic analysis was undertaken in order to identify broadly recurring themes across the dataset.

Results:

Our research found that peer support programmes are perceived as necessary in the wake of AEs, but this strength of belief stands in contrast to the operational challenges encountered in the introduction of this initiative. Overall participants' experiences of implementing the project were positive, particularly with respect to the strength of interest in the topic and the impact of the project on surgical culture. Key facilitators to successful implementation included the involvement of site team members who held managerial roles, allowing them to secure meaningful institutional support. Several common challenges were identified, including lack of time on the part of the site teams and difficulty in identifying AEs and surgeons in need of support.

Conclusions:

This study suggests that successful implementation of peer support programmes for surgeons requires significant cultural and organisational change. Through understanding surgeons' experiences of implementing the SUPPORT programme and specifically the barriers and facilitators to introducing it, we hope to improve support for surgeons after AEs in participating Trusts as well as to address an important gap in the literature in terms of qualitative data. However, this work also highlights the importance of a longer-term goal; that the existence of support mechanisms and the need to access them are no longer stigmatised and instead form an accepted part of surgical culture.

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Finally, to all the surgeons who have experienced adverse events, and to those who have yet to, but who will (because unfortunately we will). As this research emphasises, we feel primed to fix people, so when instead we harm them, it's no surprise that we are hurt, too.

For that reason, I don't expect any surgeon will stop visiting the cemetery Leriche so poignantly describes. But I do hope that the spirit of this work – and other endeavours which prioritise support for surgeons and normalise the need to do so – might meet us there.

1. Background

1.1 The Impact of Adverse Events on Surgeons

Adverse events (AEs), which can be defined as “unexpected death or serious injury to a patient before, during or after surgery” (Royal College of Surgeons of England, 2020, p.9), are unfortunately a near-certainty in any surgeon’s career (Scrimgeour & Turner, 2024). Far from a formerly estimated incidence of 1-2% (Platz & Hyman, 2012), a recent survey in the USA revealed that four out of five surgeons of all levels of seniority recalled at least one AE within the last 12 months of their practice (Han et al., 2017). Definitions of AEs tend rightly to centre around the principal consequence: the harm inflicted upon patients. However, surgeons are harmed too; in 2000, the term “second victim” was coined to describe the impact of AEs on healthcare professionals (Wu, 2000). Whilst the term has attracted controversy over the years (Tumelty, 2021), it has importantly raised awareness of the impact of AEs on healthcare professionals who care for affected patients. AEs in surgery can therefore also be operationalised as “any serious or significant change during surgical care that causes the surgeon significant distress” (Royal College of Surgeons of England, 2020).

Interestingly, it was suggested in the past that surgeons are less affected by AEs than their medical colleagues (Luu et al., 2012), and there remains a widely-held perception that surgeons are “cold and emotionally isolated technicians” (Le et al., 2023 p.183). However, there is now a considerable body of evidence demonstrating the profound impact of AEs on surgeons (e.g. Han et al., 2017; Turner et al., 2022). In fact, because of the unique (or nearly unique) nature of their professional activities, there are several reasons why surgeons may be particularly susceptible to the impact of AEs.

The delivery of healthcare in general has evolved to emphasise the role of multidisciplinary teams in the delivery of patient care rather than focusing responsibility on individuals (Dawe et al., 2024). This may help to shift the burden of the impact of AEs away from individuals and towards the system. However, AEs in surgery, especially those occurring in the

operating theatre, are still widely perceived to be the surgeon's responsibility (Le et al., 2023). As has been pointed out, "it is difficult to hold the 'system' accountable for errors associated with the 'hands' of the surgeon" (Le et al., 2023 p.183). Furthermore, the relationship between a surgeon's action or inaction and the outcome – favourable or otherwise – is considered to be more direct than in other specialties (Lander et al., 2009; Orri et al., 2015).

Unsurprisingly then, a survey of 126 American surgeons at three major teaching hospitals (Han et al., 2017) revealed the significant emotional impact of AEs: in total 84% of respondents reported a combination of anxiety (66%), guilt (60%), sadness (52%), shame or embarrassment (42%) and anger (29%). Recent work from the Republic of Ireland (ROI) through which 110 surgeons were surveyed about their experiences of AEs echoes these findings. In this study, 77% of participants were increasingly anxious, half were more angry or irritable, 60% experienced low mood and 12% drank more alcohol (O'Meara et al., 2025). A large survey of UK-based surgeons (n=445) in 2022 revealed similarly sobering findings. In the aftermath of an AE, half of the respondents were increasingly anxious, 40% reported sleep problems, one-third felt more angry or irritable and 10% admitted to increasing alcohol consumption (Turner et al., 2022). One-third of the sampled surgeons reported clinically significant post-traumatic stress symptomology, such as nightmares, avoidant behaviour, hypervigilance and detachment. To put this in context, this incidence compares to that of military personnel returning from conflict (Turner et al., 2022).

Notwithstanding the significance thereof, the impact of AEs is not limited to the immediate psychological, physical and emotional manifestations on surgeons – there is a further patient safety issue, too. Concerningly, data suggests that clinicians may be more likely to make a subsequent error in the aftermath of an AE (Fahrenkopf et al., 2008; McCay & Wu, 2012; Scott et al., 2009). This may be at least in part explained by the bidirectional link between AEs and surgeon burnout: the worse the impact of an AE, the more likely a surgeon is to experience burnout and the higher likelihood of a future error (Menon et al., 2020; Shanafelt

et al., 2010; Tawfik et al., 2018). Furthermore, the impact of AEs on surgeons may have a cumulative effect, against which seniority and experience do not appear to offer protection (Han et al., 2017; O'Meara et al., 2025; Srinivasa et al., 2019). This is echoed by a survey of American surgeons in 2010, only 30% of whom felt the ability to recover or manage the emotional impact of an AE improved with time and experience (Patel et al., 2010).

1.2 Barriers to Support-Seeking Following AEs

The personal impact of AEs on surgeons is likely compounded by the fact that surgeons do not access support in the aftermath. Turner et al. (2022) reported that a striking 43% of surgeons spoke to no-one following an AE. Lack of engagement with informal support is mirrored by data showing that surgeons are also less likely than other doctors to access formal support. In 2017, only 4% of service users of the Practitioner Health Programme, funded by the National Health Service (NHS) for doctors with mental health or addition issues, were surgeons, despite making up 11% of the General Medical Council (GMC) register (Gerada, 2017). Surgeons have been described as “a minority within a minority” in this regard (Gerada, 2017 p.262). Several barriers to support-seeking behaviours in surgeons have been identified in the literature, and this was highlighted as a major theme in the only systematic review of the impact of complications on surgeon wellbeing (Srinivasa et al., 2019).

Perceptions of surgeons – grounded in largely outdated stereotypes – likely act as a significant barrier to support-seeking. Traditionally, a surgeon was a “powerful, strong and in control white man” (Bakke et al., 2021 p.981), often branded as “abrasive, arrogant and difficult to work with” (Logghe et al., 2018 p.492). The surgical archetype may, in part, have arisen because of the profession’s historical association with the military; both soldiers and surgeons were considered the embodiment of “stoic masculinity”, and both were expected to be “bold, brave, and robust under pressure” (Arnold-Forster, 2022 p.2). The surgical caricature created a “masculinity contest culture” (Bakke et al., 2021 p.981) in which there was no tolerance for showing weakness, and it is this culture that is reliably cited as another

barrier to support-seeking (Berman et al., 2021; Pinto et al., 2013; Scrimgeour & Turner, 2024; Srinivasa et al., 2019).

Other practical and reputational considerations may act as barriers to support-seeking behaviour in surgeons, including lack of time, uncertainty or difficulty with access, concerns about lack of confidentiality, negative impact on career and stigma (Hu et al., 2012).

However, although the data clearly show limited engagement with support, this does not necessarily mean surgeons do not want to talk. A large survey of American paediatric surgeons revealed that 91% wished to be contacted after an AE, 45% of whom said no one offered to speak to them after such an event occurred (Berman et al., 2021). Perhaps this raises another issue in that the onus is often on a struggling surgeon to seek support (Scrimgeour & Turner, 2024), versus this being proactively offered as part of routine practice.

1.3 Employing Peer Support Programmes After AEs

Doctors in general are reticent to access professional support because of fear of medico-legal repercussions and because expressing vulnerability and self-doubt are discouraged by their organisations (Fall et al., 2024). This is thought to explain why doctors are more likely to seek support from their peers compared to institutional support mechanisms such as Employee Assistance Programmes (Hu et al., 2012). Peer support programmes have become a popular means through which colleagues are able to offer psychological and emotional first-aid to each other. A recent systematic review of support mechanisms for 'second victims' in healthcare found peer support is the most highly desired form of support (Simms-Ellis et al., 2025). Peer support programmes have been set up and delivered in several secondary care settings, and have been offered broadly to all employees in some cases (Cobos-Vargas et al., 2022; Keyser et al., 2021; Merandi et al., 2017; Scott et al., 2010; Trent et al., 2016; Wijaya et al., 2018) and elsewhere to particular staff groups, including pharmacy (Krzan et al., 2015), paediatric (Finney et al., 2021) and neonatal intensive care staff (Merandi et al., 2018). There are also examples of specialty and/or role-

specific programmes, including those for psychiatry doctors (Padilla et al., 2020) and nurse anaesthetists (Thompson et al., 2022).

Whilst not specific to a surgical population, several psychological benefits of peer support have been identified, some of which are particularly relevant in this context. The first is the importance of shared experience in the normalisation of emotional responses, as well as allowing the supporter to tailor their approach based on what is or is not helpful (Watson, 2017). This is likely to be important to a group for whom support-seeking has historically been stigmatised, and who have been found not to engage with existing support structures. Another advantage of the model is that the peer supporter occupies a liminal space between the roles of the service user and the mental health worker (Watson, 2017). This may create an important bridge for surgeons between the two (Gillard et al., 2015) without over-formalising or pathologising the process, which could otherwise adversely affect engagement. Furthermore, support can be offered in both social and practical ways (Mourra et al., 2014), which may be likely to appeal to surgeons, who often lean towards extraversion (Sier et al., 2023) and identify as ‘fixers’ and ‘doers’ (Brown & Gilliam, 2020).

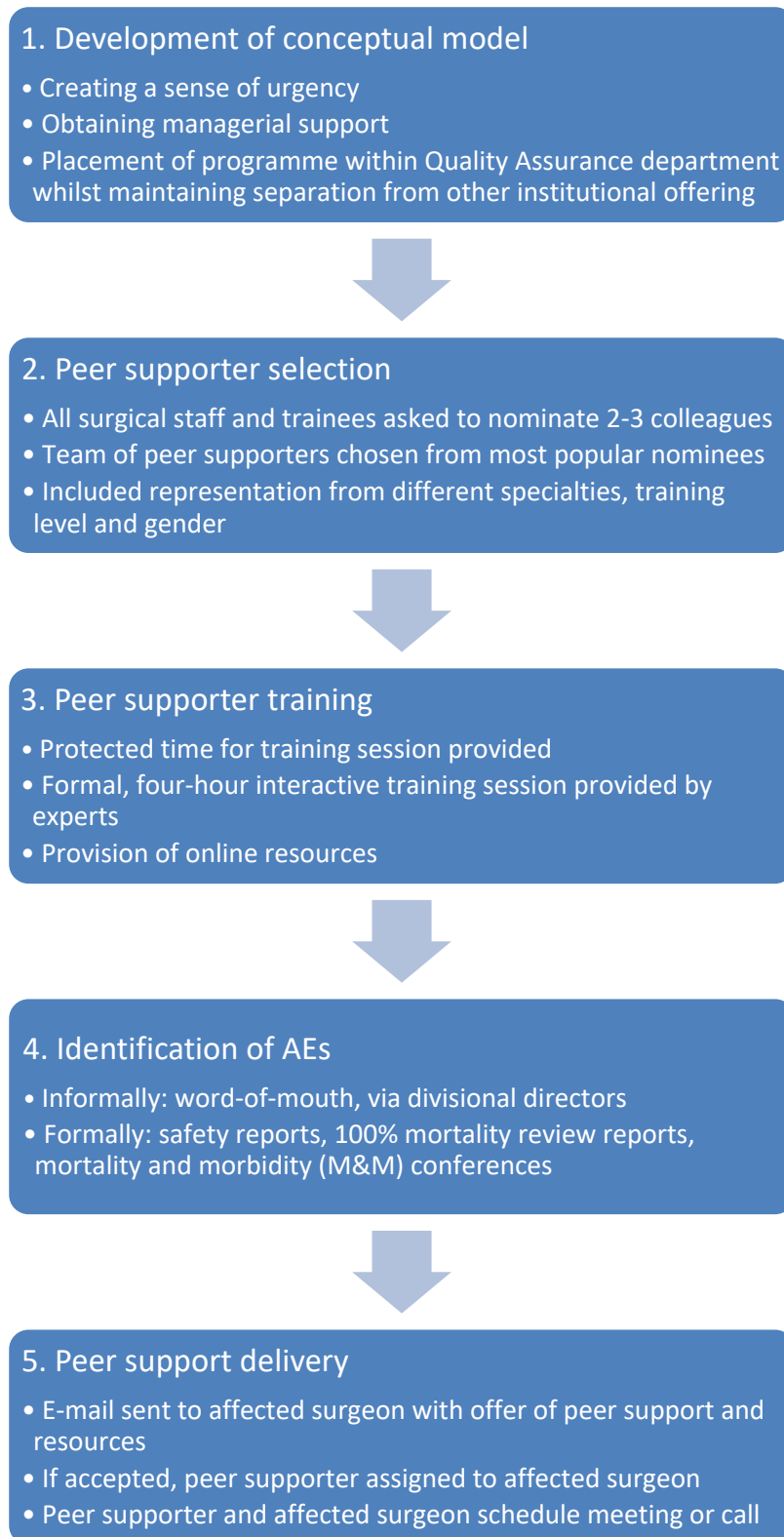
Although the peer support model has now been described in several healthcare settings, details of their design, delivery and efficacy are often omitted from publication (Krzan et al., 2015; Scott et al., 2010). One programme for which this is available is the Resilience in Stressful Events (RISE) programme at John’s Hopkins Hospital, wherein peer support was offered to all healthcare professionals involved in an AE in 2010. Support was offered on a one-to-one or group basis to staff members who initiated contact. However, the programme was largely used by nursing staff, and doctors’ engagement with it was poor (Edrees et al., 2016). This followed a similar programme at the Brigham and Women’s Hospital in 2006, through which a multidisciplinary team of surgeons, anaesthetists and nurses received training to offer group interventions for individuals involved in AEs. The programme was initially underused by doctors, who felt uncomfortable showing vulnerability among non-

physician colleagues, but the uptake improved when it was redesigned to offer individual support in 2009 (Shapiro & Galowitz, 2016).

A team at Massachusetts General Hospital, recognising that surgeons often talked to close colleagues in the wake of an AE (Christensen et al., 1992; Hu et al., 2012), highlighted the validating experience for surgeons receiving support from a peer who had a unique understanding of their situation, having “been there” before (El Hechi et al., 2019 p.932). This prompted them to adapt the Brigham and Women’s Hospital re-designed, one-to-one offering, to launch the first surgeon-specific peer support programme in the USA. They outlined a five-step process of creating their peer support program, along with important considerations for each, adapted and shown in Figure 1 (El Hechi et al., 2019).

Figure 1

Suggested five-step process of creating a surgeon-specific peer support programme



Within one year, a total of 47 offers of peer support were made, 81% of which were accepted by affected surgeons, who each participated in one or more peer support conversations. The impact of the programme was assessed at one year by sending participating surgeons (both those who delivered and had received peer support) an anonymous survey which included Likert-based statements about their views of the programme as well as free-text responses. Most (89%) participants were satisfied with the programme, the safe and trusting environment it afforded (73%) and the timeliness of peer support (83%). Overall, 81% indicated it positively impacted the departmental “safety and support” culture through raising awareness of the need to support surgeons in times of difficulty (p.931). While these results are promising, the peer support programme was delivered in a single institution, which may affect the generalisability of the findings. Additionally, the results may have been impacted by non-response bias, as the 67% responding to the one-year impact survey may not have included views of those who were less interested in or supportive of the programme. The authors also identified important areas for improvement for future endeavours. These included improved identification of AEs, and in turn of surgeons in need of support, and the requirement for increased awareness of the programme (El Hechi et al., 2020).

Surgeon-specific peer support programmes have slowly grown traction in the USA. For example, a surgical specialty-based peer support programme (summarised in Figure 2) was implemented recently by the American Pediatric Surgical Association (APSA) (Fall et al., 2024). The programme was evaluated by sending an online survey to APSA members who had received peer supporter training, which included Likert-type scale questions about their readiness to deliver peer support and experiences of doing so. Data was also collected about practical aspects such as the number of and reason for referrals. The authors also highlight pre-emptive barriers to implementation and suggested solutions (Table 1), although this was published after the programme had been established.

Figure 2

Summarised process of APSA peer support programme

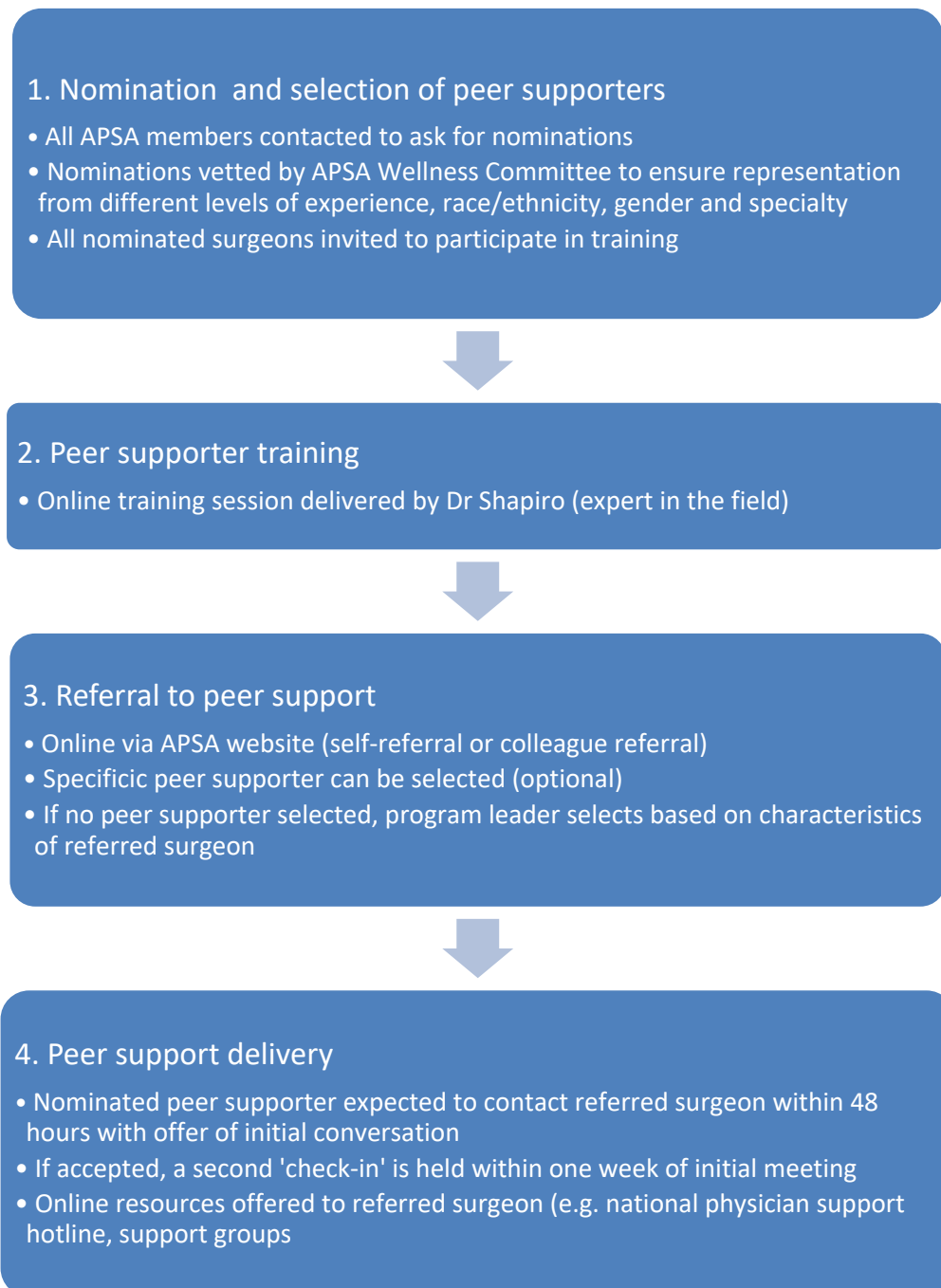


Table 1

Barriers to success of a peer support programme and how to overcome them

Obstacle	Strategies used
Difficulty in garnering referrals, especially self-referrals	1) Promotion of the programme through society-sponsored platforms: • Mass membership e-mails, social media, presentations at annual society meetings including plenary session with testimonial from APSA president • Elected APSA leaders and senior surgeons sharing personal stories 2) Encouraging referral of surgeons by friends and colleagues with a system to respond with nuance and compassion
Concern about lack of confidentiality if AE results in malpractice lawsuit	• Peer support focused on normalising appropriate reactions to AEs and processing emotions rather than analysis of clinical details of the case, and peer supporter training reflects this approach • No notes taken by peer supporters during interactions and programme documentation pertains only to practicalities e.g. number of and reason for referrals with identifiable information about supported surgeons de-anonymised

	• APSA Peer Support Frequently Asked Questions (FAQs) includes specific guidance about medicolegal considerations and reassurance about use of the programme
Concern about potential liability of APSA if supported surgeon commits act of self-harm	• Dedicated disclaimer provided on peer support portal of APSA website

In the 12 months after the programme was launched, a total of 15 referrals were made. In contrast to El Hechi et al., (2019), the APSA programme was not specific to support in the wake of AEs, and only 36% of referrals were made for this reason. Although the numbers are therefore small, no one who was referred declined the offer of support. Six months after the peer support training session, survey responses were obtained from 34% of surgeons trained to deliver peer support. While 94% felt prepared to offer peer support, 77% expressed interest in additional and/or refresher training. Interestingly, while most (absolute numbers are not reported) trained peer supporters had not been asked to provide formal support to a colleague through the programme, 80% had used the skills in more informal settings, and 76% reported helping colleagues after AEs (Fall et al., 2024).

Importantly, both the Massachusetts and APSA groups highlight one of the key benefits of peer support programmes which has also been identified in a systematic review of second victim support resources (Busch et al., 2021): the impact on surgical culture. The existence of a peer support programme in and of itself challenges blame culture and stigmatisation of mental health issues that sends a powerful message to healthcare institutions and workforces about the importance of psychological and emotional support (Busch et al., 2021;

Fall et al., 2024). This in combination with engagement from those in leadership roles and associated publicity normalise both the occurrence of AEs in surgery and the need to provide support to surgeons in the aftermath (Fall et al., 2024).

1.4 The Surgeon Peer-led Post-incident Response Teams (SUPPORT) Quality

Improvement Collaborative

In response to: 1) growing evidence as to the impact of AEs on surgeons, 2) the likely inadequacy of and lack of engagement with existing support mechanisms, and 3) the gathering momentum of peer support, The Royal College of Surgeons of England (RCS England) produced a good practice guide with the aim of improving support for surgeons during this critical period (Royal College of Surgeons of England, 2020). The guidance includes a practical framework for institutional support for surgeons, including the recommendation that surgeons are routinely offered a peer support conversation following an AE. However, in accordance with background literature, the introduction of this support culture in practice has been challenging. In order to address this, following the success of several RCS England-led, clinically-oriented quality improvement (QI) collaboratives (Bamber et al., 2019; Stephens et al., 2019), the College commissioned a QI programme with the aim of supporting participating hospitals to design, deliver, sustain and evaluate a peer support programme for surgeons after AEs.

The Surgeon Peer-led Post-incident Response Teams (SUPPORT) QI collaborative launched in January 2024 and has brought together surgeon-led teams from 12 hospital Trusts across the UK and The Republic of Ireland (ROI). The 'live' phase of the project took place over a 16-month period until March 2025. In a similar manner to the work of El Hechi et al. (2019) and Fall et al. (2024), peer support training and relevant resources were provided to SUPPORT participants (Appendix F). However, there were several key differences between SUPPORT and the USA-based programmes. Having received training in peer support, SUPPORT site teams were in turn responsible for training a cohort of peer supporters at their institutions. Furthermore, decisions about selection of peer supporters,

promotional strategies and means of referral to the programme were left to the discretion of the site teams. This is in recognition of one of the potential strengths of the QI model, in empowering participants to implement projects within their local organisational context. SUPPORT has also expanded on previous offerings by providing didactic, delivered content, in order to help site teams develop the required skills and understanding to successfully implement a peer support programme. In total, SUPPORT involved four in-person all-day meetings, three webinars and five small-group meetings, the latter of which were used as an informal opportunity to share ideas, learning and challenges. The objectives for the site teams and examples of how SUPPORT facilitated these are summarised in Table 2.

Table 2

Summary of site team objectives, relevant examples of delivered content and resources provided

Objective	Example content/resources
1) Developing the skills and confidence necessary to conduct effective peer support conversations	• Peer support training provided to participants during in-person meeting • Resources to include peer supporter 'checklist' and online modules made available (Appendix F)
2) Empowering participants to implement a peer support initiative within their organisations	• Practical steps required to implement the programme outlined during launch meeting • Small group meetings held to encourage collaborative discussion between sites and provide the opportunity to learn from others' local context
3) Promoting a culture of care within the organisational environment	• Psychoeducation on cultivating compassion for both self and others in the aftermath of AEs, e.g. talk entitled "How we view failure and forgiveness" • Developing understanding how issues of equality and diversity may impact support-seeking behaviour, e.g. talk entitled "Surgery and diversity"

4) Challenging prevailing attitudes towards AEs and support seeking	• Focus on normalising common psychological reactions to AEs, e.g. talk entitled “Normal psychological reactions to AEs”
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SUPPORT has involved ‘delivered’ content (in the form of in-person meetings, online webinars and small group sessions) as well as interactive opportunities for participants to share learning and reflect on progress and challenges of implementation with colleagues. To our knowledge, SUPPORT is the first and only UK-based, multi-centre, surgeon-specific peer support programme of its kind.

1.5 Rationale for the Current Study

While there are promising findings about the usefulness of peer support programmes for surgeons, no research to date has focused on peer support provision in the UK. USA-based programmes (El Hechi et al., 2019; Fall et al., 2024) may not be entirely translatable to UK and ROI practice, as there are potentially considerable differences between healthcare systems. While SUPPORT has been implemented across 12 hospital trusts in the UK and ROI, no research has been carried out to understand experiences of surgeons who have been involved in its introduction.

Moreover, while groups in the USA have published some outcome data as to the efficacy of their programmes, there is limited information about the process of having introduced them. Fall et al., (2024) include suggested barriers and facilitators to the implementation of peer support, but these are framed as having been identified prospectively, rather than having been identified through experiences of surgeons involved in the programme. Recent qualitative research has been published about the effectiveness of a trauma support programme (TSP) for healthcare workers in a large UK hospital (Teoh et al., 2025). Peer

practitioners and psychologists providing TSP were interviewed and several important themes were identified, including normalisation of reactions to trauma, improving awareness of local resources and contributing to compassionate workplace culture through reducing stigma and encouraging support-seeking behaviour (Teoh et al., 2025). Although this programme is not specific to surgeons, given the well-known cultural barriers to support-seeking in the profession, these findings are likely to be translatable. Whilst qualitative data has been published pertaining to surgeons' experiences of AEs more generally (Orri et al., 2015; Turner et al., 2022), there has been no qualitative research about their experiences of implementing peer support programmes, and specifically what relative successes and challenges were encountered in doing so.

Qualitative research allows us to gather rich data about perspectives and experiences of surgeons involved, and to gain insights into what facilitates or interferes with implementation of peer support across the different local contexts. This detail has been largely missing from accounts of surgeon peer support programmes to date. Qualitative approaches have been identified as being particularly well-suited in providing insights into organisational change, as this is “an emergent, fluid, messy and human phenomenon” (Grey et al., 2012 p.129). We aim to address this important research gap by carrying out interviews with surgeons who have taken part in the SUPPORT collaborative in order to understand their experiences of implementing a peer support programme in their hospital Trust. This research considers the following research questions:

- 1) What are surgeons' perceptions of the effectiveness of a peer support programme to support surgeons after AEs? (RQ1)
- 2) What are surgeons' experiences of barriers and facilitators to the implementation of a peer support programme to support surgeons after AEs? (RQ2)

2. Methods

2.1. Participants

A total of 12 hospital Trusts and health boards signed up to SUPPORT, from which 55 individuals volunteered to take part in the project. Participants at each Trust formed a 'site team' – a core group of participants responsible for the implementation of the project at their institutions – who attended the delivered aspects of the programme and received training in providing peer support. The site teams were largely comprised of consultant surgeons (Table 3).

Recruitment for this study took place between January-March 2025. All members of the site teams were contacted by e-mail. The e-mail was sent as part of routine and planned correspondence, informing them of the intended research, and asking them to consider participating in a semi-structured interview. An advert with further information (Appendix A) and the Participant Information Sheet (PIS) (Appendix B) were attached to the e-mail.

The target number of participants was initially between 8-10 participants. A sample of this size is likely to reach saturation according to a recent systematic review (Hennink & Kaiser, 2022). While the recommended sample size for thematic analysis varies from 6-16 interviews (Braun & Clarke, 2021) the idea of predetermining a sample size prior to data collection has been recognised as problematic for interpretative types of qualitative analysis where sample size is often more pragmatically shaped by resources and time (Braun & Clarke, 2021). Thus all 55 potential participants were invited to take part in the study, and sample size was determined by those who opted in to the study.

A total of 16 site team members volunteered to participate in and completed an interview. Participant demographics are shown in Table 3 below. Further detail such as age and specific job role is not included to protect the participants' confidentiality, because some participants held unique roles within the sample which would make them easily identifiable – for example, only one anaesthetist took part in SUPPORT and was interviewed.

Table 3

Interview participant demographics and job roles

Participant code	Gender	Job role
P1	Female	Surgeon
P2	Female	Non-surgeon
P3	Female	Non-surgeon
P4	Male	Surgeon
P5	Female	Surgeon
P6	Male	Surgeon
P7	Male	Surgeon
P8	Male	Surgeon
P9	Male	Surgeon
P10	Male	Surgeon
P11	Male	Surgeon
P12	Female	Non-surgeon
P13	Female	Surgeon
P14	Female	Surgeon
P15	Female	Surgeon
P16	Female	Surgeon

Note. Non-surgeons included anaesthetists and psychologists in this sample.

2.2. Procedure

Participants who expressed interest in taking part were contacted via e-mail by the researcher to provide them with further information, obtain consent and organise the interview. An online participant agreement form (Appendix C) and the PIS were attached to each e-mail. Participants consented by returning a signed consent form via email ahead of the scheduled interview. All correspondence related to the organisation of the interviews took place via e-mail between the researcher and the participant. Each interview was arranged at

a date and time of the participant's choosing. All interviews were held online using the participants' preferred platform, which in this study was unanimously Microsoft (MS) Teams.

The decision to use online interviews was largely born out of pragmatism, in the interests of minimising inconvenience and to accommodate participants' schedules. Online interviews are an alternative means of data collection which may overcome some of the potential challenges of the face-to-face equivalent (Braun et al., 2017). Advantages of online interviewing include cost-effectiveness, efficiency of data acquisition and flexibility (Wakelin et al., 2024). Furthermore, there was a large geographical spread among participants in this study, and the online interviews eliminated the impact of travel both from a practical and environmental perspective.

In accordance with relevant guidelines (Braun et al., 2017), an interview schedule (Appendix D) was devised primarily in order to answer the two main research questions, but also included questions pertaining to the practicalities of implementing SUPPORT and feedback about the delivered content of the project, to inform future iterations. The schedule was circulated for approval among the wider supervisory team, made up of surgeons and psychologists with collective expertise in surgeon wellbeing, some of whom are also part of the SUPPORT project team.

Rapport has been identified as a key facilitator to participants sharing rich and detailed information in qualitative research interviews (Leslie et al., 2023), and was especially important in this study due to the potentially sensitive nature of the topic. Some of the process of developing rapport between the researcher and participants may have taken place prior to the interviews, through the researcher's role in the SUPPORT project. Each interviewee was peripherally known to the researcher because of mutual attendance at relevant meetings and webinars, which afforded the opportunity for some, albeit brief, interaction. The researcher's engagement with the interviews was informed by the methodological framework of CHE: Connectivity, Humanness and Empathy (Brown & Danaher, 2017), principles which were enacted by considering several reflective questions

pertaining to each domain, to optimise the research relationship during the interview process. Examples of these are shown in Table 4 below.

Table 4

Examples of relevant considerations pertaining to each CHE domain

Connectivity	Humanness	Empathy
What strategies can be adopted to help build trust and overcome experiences of vulnerability, cautiousness and apprehension?	How can I overcome emotions expressed by participants such as vulnerability, cautiousness and apprehension?	How easily can empathy shade into being perceived as endorsing or critiquing specific attitudes, behaviours and values on the part of the participants or others?

Rapport was also built by using conversational opening questions at the start of the interview before recording began, with the aim of allowing the participants to feel as comfortable and at ease with the experience as possible.

The interviews were recorded using the dedicated, in-built function of Microsoft Teams. The length of the interviews was between 39 and 82 minutes. The recordings were transcribed using a professional transcription service. All participants were e-mailed a copy of a debriefing document after the interview had taken place. Data collection took place over a four-month period, between January-April 2025.

Semi-structured interviews have been identified as a powerful means to acquire in-depth information as well as conferring advantages of flexibility and adaptability, especially when compared to a structured equivalent. However, relative direction is maintained in comparison to an unstructured interview. This compromise allows adjustments to be made in real-time depending on responses so as not to miss important insights, whilst holding direction as the

topics have been pre-determined (Ruslin et al., 2022). While focus groups can also be a useful way of collecting data about a range of perspectives (Then et al., 2014), our research and experience of working with surgeons has demonstrated the considerable logistical challenges of doing so. We had previously planned to carry out group work with surgeons as part of a randomised controlled trial (Greville-Harris et al., in press), but after organisational challenges around surgeons' availability and their consistent preference for individual participation the study was run individually. We therefore felt interviews were the best fit for this research.

2.3. Data Analysis

Thematic analysis is a method used for "identifying, analysing and interpreting patterned meanings or 'themes' in qualitative data" (Braun et al., 2014 p.95). Specifically, reflexive thematic analysis has been identified as a suitable method for research questions focused on experiences of interventions as well as influencing factors and perceptions, which are premises underpinning the two research questions in this study (Braun et al., 2014). One of the strengths of reflexive thematic analysis is that it is a flexible approach in which subjectivity and reflexivity are embraced (Braun & Clarke, 2019). However, it simultaneously provides a rigorous framework for data analysis, for which a six-step process has been proposed: 1) Familiarisation with the data, 2) Generating initial codes, 3) Generating themes, 4) Reviewing potential themes, 5) Defining and naming themes, and finally 6) Producing the report (Braun & Clarke, 2006).

Although quality guidelines in qualitative research are not considered definitive, good practice for qualitative research was considered at all stages of the process and informed the approach to the study design, sampling, data collection and analysis and reflexivity (Mays, 2000). In line with the Critical Appraisal Skills Programme (Critical Appraisal Skills Programme, 2024) checklist for qualitative research, attention was given to researcher reflexivity as well as contradictory data. A clear and transparent data trail of codes and identified themes/subthemes was also kept (Ahmed, 2024). This was maintained principally

by using NVivo Pro 20 Release 1.6 (1121) software, which would allow another researcher to access the data codes, but also through the use of comprehensive thematic tables to record key definitions, links and quotes for each theme and subtheme. An example thematic table is shown in Appendix G.

There are potential advantages and disadvantages to second-coding in qualitative research. Second-coding can bring variety and breadth of perspective to data analysis, and allow refinement of codes through identification of disagreement between coders. However, disadvantages include inconsistencies in reflexivity which may impact the dataset, and that the requirement for agreement between coders may be at the expense of interpretive insight (Keene, 2021). Our data analysis included second-coding of one one-hour interview by the principal supervisor to obtain interpretive insights from a researcher with differences in professional background. This was felt to be of particular importance for this research in developing our understanding of participants' reflections on different models of support – for example, whether this is delivered by a surgeon, or a professional from another background (namely a psychologist) (Keene, 2021).

2.4. Reflexivity

Reflexivity in qualitative research can be defined as “the active process whereby each team member or individual... examines the dynamic and reciprocal relationships between personal experiences and positions, social and environmental contexts, conscious and unconscious biases, and the research process and outcomes” (Braund et al., 2024 p.147). Through reflexivity, individuals are active participants in the research process, in which their position in the world is acknowledged, in order to better understand the limitations of their knowledge and understand the social context of others.

My experiences because of my background as a surgical trainee with an interest in surgeon wellbeing will of course have impacted my engagement with this research and with interview participants. I have had personal experience of an AE at work, when during the course of an

elective operation I caused an injury to a patient's bladder. Although this is a well-recognised risk which patients are consented for and it required conservative management only, I remember very well how devastated I was, having literally watched myself 'harm' a patient with my own hands. I was fortunate to have been well-supported, but even then, this was a stand-out moment in my career. I am therefore naturally empathetic to the interview participants' experiences, which could have affected some of the coding process, the assignment of which could be unconsciously influenced by my own. I mitigated this to the best of my ability by following relevant guidelines as previously mentioned, to ensure the process of analysis was as data-driven as possible.

Furthermore, through my involvement in the SUPPORT project, I was at least superficially familiar with the background literature, which again could have had an impact on data analysis. As mentioned, I knew some participants peripherally, and through interactions with them during the course of the project, I may have been aware of some of their views about relevant topics prior to the interviews. In the initial stages I challenged myself to code each sentence as literally as possible, by asking myself, "what does this say?" rather than, for example, "what do I think this might mean?" Data from one interview transcript was also analysed by a second coder, with a background in psychology rather than surgery, which may have helped to offset the potential influence of my position on the research. However, this colleague was also part of the SUPPORT project team, and like me, was therefore not approaching the data from a place of naivety.

Whilst I have considered some of the potential ways in which my role could have affected the acquisition and interpretation of data in a critical sense, there are also some potential benefits in facilitating both my own and participants' engagement with the research. Knowing that surgeons generally feel more comfortable opening up to surgeons rather than colleagues from other professional backgrounds, it is possible that participants felt more prepared to share their experiences with me. The potential power dynamic was likely favourable for interviewees, as I am more junior than all of the surgical participants, who may

have felt more at ease being honest as a result. Because of my familiarity with the context in which participants work and the language and terminology involved, the interviews may have flowed more naturally than if they had been done by someone without relevant experience, which may have had a positive impact on data acquisition.

2.5. Ethical Considerations

Ethical approval for this research was granted in December 2024 (Ethics ID: 60068), with an amendment accepted in January 2025. The first page of the ethics checklist can be found in Appendix E.

One of the primary ethical concerns in this research was the potential for causing participant distress, given the nature of the topic. While participants were not asked about their personal experiences of AEs, it was anticipated this was likely to inform or directly form part of their responses, for example when asked about their interest in the project. In order to mitigate this as far as possible, the PIS included comprehensive information to emphasise that taking part was completely voluntary, participants could withdraw from the interview at any time and were not required to answer any question or questions they did not wish to answer. This information was reiterated verbally to participants by the researcher prior to the commencement of the interview (Appendix D). Furthermore, participants could withdraw their data for a period of seven days after the interview before the recording was sent for transcription. A debriefing document was sent to all interview participants which included detailed information about support resources that could be accessed in the event of distress.

Other important ethical considerations included participant confidentiality, which was largely achieved through the fact that all correspondence related to the interviews was between the researcher and participant only, including the processes of obtaining consent, scheduling and debriefing. Only the researcher was aware of the participants' identities. Interview recordings were stored on a password-protected computer and transcribed using a professional transcription service, the use of which received both ethical and legal approval

from Bournemouth University (BU). All identifiable information was removed from interview transcripts as soon as these were received from the professional transcription service, and each participant was assigned an anonymous participant code, known only to the researcher.

Data protection was maintained through careful consideration as to how data would be stored, accessed and disposed of. All data, including completed participant agreement forms and interview transcripts, were stored on the researcher's secure BU OneDrive account. Incidentally collected e-mails from interview participants were deleted once communication was complete. Interview recordings were deleted as soon as analysis of the relevant transcript was complete. Transcription files and participant agreement forms will be deleted from the researcher's BU OneDrive account once the degree award has been confirmed. In line with BU data policy, anonymised transcripts will be uploaded by the researcher to Brightspace. The anonymised dataset will also be added to BORDaR. Anonymised transcriptions saved within Nvivo will be accessible to the research team and can be provided to authorised BU staff upon request for audit purposes. Finally, completed digital participant agreement forms will be retained by the researcher's supervisor for a period of five years in line with BU policy. Further details of storage, access and disposal of data can be found in Appendix E and this information was also included in the PIS.

3. Findings

Four main themes, each with between three to four subthemes, were identified during reflexive thematic analysis. These themes and whether they related to RQ1 (perceptions of effectiveness), RQ2 (experiences of barriers and facilitators) or both are shown in Table 5.

Table 5: Themes, subthemes and relevant RQ(s)

Theme	Sub-theme	Relation to RQ1/2
1) Importance of SUPPORT	1.1 Normalisation of support for surgeons – “If this happens, then this is what we do.”	RQ1
	1.2 Perceived necessity of SUPPORT – “It’s not just about being kind.”	RQ1
	1.3 Peer support: one size doesn’t fit all “We’re not wanting special treatment. We’re just wanting specific treatment.”	RQ1
2) Surgical culture	2.1 The pressure of professional identity – “You’re a rockstar at it, and then you move on.”	RQ1, RQ2
	2.2 The shame and stigma around support-seeking – “There’s something wrong with them for being so vulnerable... maybe they should go off and do psychiatry or something.”	RQ1, RQ2
	2.3 Generational cultural shifts – “I think most younger surgeons coming through are much more aware of a holistic approach to looking after ourselves.”	RQ1, RQ2
	2.4 The impact of SUPPORT on surgical culture – “Actually, this is how we do things around here.”	RQ1, RQ2

3) Barriers to implementation	3.1: Systemic lack of awareness and institutional integration – “Really? Surgeons need help? Support? Really? Why?”	RQ2
	3.1: Site team lack of time – “I think I can spend more time on this, but I don’t have time.”	RQ2
	3.3: Peer support training – “I think a lot of it is, am I going to say the wrong thing?”	RQ2
	3.4: Difficulty in identifying AEs, surgeons in need, and referral to SUPPORT – “We’re missing access to surgeons who really need us, somehow.”	RQ2
4) Facilitators to implementation	4.1 Influence of site teams – “It’s important to have a role of responsibility.”	RQ2
	4.2 Institutional support – “Once it goes there... from the executive team, or higher levels, the medical director... from that point onwards it’s very easy.”	RQ2
	4.3 Practical facilitators	RQ2
	4.4 Integration with psychology – “We really benefit from having the psychology team involved.”	RQ2

3.1. Theme 1: Importance of SUPPORT

This theme captures participants’ attitudes towards SUPPORT, including its perceived legitimacy and the relevance of a formal peer support programme, which is intrinsically linked to surgeons’ unique ways of working. The strong conceptual support for the programme stands in contrast to the operational and cultural barriers, such as lack of

institutional support and the shame and stigma associated with support-seeking, explored elsewhere in the analysis.

Subtheme 1.1: Normalisation of support for surgeons – “If this happens, then this is what we do.”

There was a clear acknowledgement of AEs as an inevitable part of surgical practice: “I don’t think there’s any surgeon who hasn’t [experienced an AE] if they’ve done enough surgery” (P15). Given the widespread acknowledgement of the inevitability of AEs, several participants identified a key aspect of the role of SUPPORT in the normalisation of AEs occurring: “...this makes it that this is acceptable, and this is normal. Things can go wrong at times, and when it goes wrong, when you are in difficulty, there is help available” and that this is the intended message behind the programme: “What it should feel like: this is something which can happen to anybody” (P8).

The existence of the programme was also felt to be important in normalising psychological reactions to AEs, particularly given the perceived directness of a surgeon’s impact on patient outcomes: “...that’s a human life that was in your hands, and if something goes wrong... that can have a significant impact on you” (P2). Furthermore, the existence of the programme’s role in normalising support-seeking was also acknowledged by many participants, particularly in terms of the importance of this work and the need to integrate this as normal everyday practice: “I think supporting surgeons should look like something that is normal, actually, because of the kind of work that they do” and that this is significant, given it is “...a big piece of work, actually, normalising accessing support” (P2).

P10 used the comparative example of how occupational injuries are dealt with to illustrate the need to enmesh SUPPORT into clinical life, describing the ideal response to supporting surgeons as “...like if you have a needlestick injury. The hospital is quite careful about it. This has to be within the culture, that it’s just protecting your staff....”

Integration of peer support into routine surgical practice was also identified as an important contribution towards addressing the stigma surrounding AEs and accessing support in the aftermath, identified as key issues within surgical culture. Participants mentioned the peer support model as particularly valuable in challenging unhelpful attitudes towards support-seeking: “I think it will allow everyone to see that it is not weak to ask for help” (P1).

Subtheme 1.2: Perceived necessity of SUPPORT – “It’s not just about being kind.”

The inevitability of AEs and cultural normalisation described by participants in Subtheme 1.1 may help to pave the way for SUPPORT to be viewed as a necessary, rather than optional, support mechanism. There was an emergent sense that peer support for surgeons should be considered an essential part of surgical practice which has historically been lacking: “I think it’s been hugely under-recognised, under-reported and I think it’s of great value to the profession” (P6).

This collective perception of SUPPORT’s necessity appeared to be grounded in several things, including the potential gravity of the impact of AEs, as articulated by P9:

“...it should never be underestimated, how bad it can be. And we know we want to prevent suicides, that is the real end result of some of these AEs... it’s not a fantasy. It actually happens. But... below that, there are people completely broken who never get back to the level that they were at... it is very, very serious”.

The need for support in acknowledgement of the severity of the impact of AEs was also linked to the unique nature of surgeons’ work and the resulting weight of responsibility, as P5 reflected: “We know that surgeons suffer quite significantly in the aftermath of AEs or complications, because of the direct correlation between their actions and the event”. As well as the necessity of addressing a longstanding gap in surgeon wellbeing infrastructure, participants also linked the importance of emotional recovery in the wake of AEs to maintaining their sense of professionalism, patient safety and effective team-working: “This

is why this is important. It's about keeping people at work, keeping them productive, looking after our patients properly, and creating the right environment for the Trust" (P6).

The perceived justification for and legitimacy of SUPPORT was also frequently linked to the evidence base around surgeons not accessing support in the aftermath of AEs: "...there is good evidence for why. I think the statistics of 40% of people speak to nobody at all is really, really sobering" (P15). This was something surgeons and non-surgeon participants alike had not necessarily appreciated before their involvement in the project: "...having been told more about the available literature, I now appreciate why surgeons need this bit of special additional help... to try and improve their journey back to normal function" (P1).

Subtheme 1.3: Peer support: one size doesn't fit all – "We're not wanting special treatment. We're just wanting specific treatment."

There was a strong sense of the value of peer support from all participants, regardless of their professional background. The unique professional activities and responsibilities of surgeons appeared to be a strong influence for surgeons in this subtheme in terms of "...talking to somebody who gets it... what it's like in the trenches day-to-day... the kind of responsibility you have and how it is very different when you operate on someone" (P4).

Others reflected that peer support is a natural extension of the social aspects of surgical life "...because surgeons quite like talking to other surgeons, for lots of different reasons... there are always surgeons talking to each other down the corridor" (P1).

Some participants' insights also linked to Subtheme 1.1 through normalisation of responses to AEs and the need for support being rooted in the nature of the work:

"...there is definitely something about how surgeons engage with each other around it being okay not to be okay, as well. Also, it not feeling kind of pathologising. So if someone suggests, "Go and see a psychologist or the wellbeing team," then you want to say, "Actually, it's not a mental health issue. It's just because of the nature of the work"" (P2).

Other participants' insights were linked with the data-driven necessity identified in subtheme 1.2, "...there's a lot of evidence to back it up" (P12).

While the value of peer support was clearly identified in this subtheme, there was also recognition of the potential nuance in its delivery. For example, P11 identified the importance of timeliness in the offer of peer support: "I think it needs to be very quick in responding to that event". However, they also went on to say:

"...how soon after, that will really depend on the individual. Some surgeons might not want to have that soon after, they may feel it suffocating, but that has to be left to the individual person... when they are ready to talk to, I think that's the right timeframe".

This subtheme highlighted an interesting tension in the desire for standardised, yet individualised, support. Some expressed the "...emphasis has to be on the individual, and then tailor the support they need, depending on what they need. Because that's going to be very variable" (P11). However, other participants felt there is a "...role for trying to at least make some effort to provide a little bit more standardised support for surgeons" (P16).

Another interviewee highlighted this in practical terms: "I think actually having the checklist, that's really, really useful" (P15) which was directly at odds with another's views that "...it shouldn't be... they call and go through the checklist of questions.... Lots of things are tick-box exercises, and may not be as effective as an honest one-to-one conversation" (P10).

Although the merits of surgeons supporting other surgeons were collectively identified, some participants pointed out some of the important detail underpinning this. Firstly, there is a requirement for training in peer support, as otherwise the discussion can easily become: ""Well, let me tell you about what happened to me" kind of scenario, instead of actually supporting a surgeon" (P5). Similarly, others raised concerns that "...you can be drawn into talking more about the technical aspects of what happened... and stray away from the psychological support that you need" (P16). Some participants suggested this could be mitigated through representation of peer supporters from different surgical specialties, which:

“...gives you that one degree of separation from the technicalities around what happened and you have much less chance of getting sidetracked by all of that” (P4). Interestingly, a participant who had personal experience of providing peer support felt differently: “...actually, because it was technically such a difficult urology thing, they probably did benefit from having a urologist involved in it directly for advice, because it’s been tricky” (P9). Some participants felt peer support could be successfully delivered by a professional from another clinical background. Reflecting on the positive input from their non-surgical colleague (P3), P6 felt, “I don’t think it necessarily needs to be a surgeon but it certainly needs to be someone with insight into the surgical work”.

Most participants indicated that the co-existence of and ability to access psychological support was an important aspect of SUPPORT. P4 provided insights from a surgical colleague who had accessed psychological support, which “...really helped, and I don’t think that I would have got that from another surgeon... I have spoken to other surgeons about stuff before... and it always ends up in, “Yes, I’ve had worse,” or, “I’ve had different,” or, “It’s not that bad””. Overall, it seemed participants felt there were advantages and disadvantages of both approaches, with P4 summarising “...a hybrid model probably is one that would work”, where surgeons have access to both surgeon-specific and psychological support. Specifically, “...having a bit more formal backup... from our psychology department, I think would embolden some of the peer supporters a little bit” (P4). This was echoed by reflections from a psychologist participant who had been approached by a surgeon who expressed a preference to talk to them, rather than to another surgeon. Their surgical colleague, also an interview participant, felt this was evidence of success of the programme, given the low uptake they had previously seen in surgeons accessing psychological support.

3.2. Theme 2: Surgical Culture

This theme explores the cultural landscape in which SUPPORT has been introduced, and considers how the ‘surgical identity’, generational attitudes and stigma around perceived

vulnerability could impact the implementation of the programme. It also considers the ways in which the introduction of SUPPORT is perceived to have impacted surgical culture.

Subtheme 2.1: The pressure of professional identity – “You’re a rockstar at it, and then you move on.”

This subtheme highlights both internal and external expectations of surgeons which have shaped a deeply-entrenched ‘surgical identity’, reinforced by peers, colleagues and culture, and can act as a powerful barrier to support-seeking. Surgeons like P4 describe the internal manifestations of this in the “...sense that we have to be, you know, quite hard and not show any vulnerability”. This sentiment is echoed by P6’s reflections that “It’s a bravado thing. I see it so often. I think there is this stiff upper lip attitude in surgery of, “We must carry on. Just buck up. Carry on””. These internal pressures were intrinsically linked to surgeons’ sense of professional identity, which was perceived to be threatened by any demonstration of vulnerability, particularly in their position as leaders of surgical teams. P4 spoke of the:

“...fear of what impact that might have on this rather superior feeling that surgeons have when they walk into an operating theatre, that they’re in control, they’re in charge... I think people would rather just store it all in than have to feel that that superiority is being somehow eroded”.

An interesting potential tension was in one participant’s reflections that having a degree of machoism in surgery might be positive: “...in a way, you need a little bit of that, otherwise you would never cut someone open....” (P13). The difficulty in achieving the balance required for appropriately diffident surgical leadership was most explicitly articulated by P9: “You’ve got to ooze self-confidence for people to believe in you, and that doesn’t come then very well with humility and vulnerability of, “I’ve f***ed up and it’s all gone horribly wrong””.

Some participants felt that the expectations of surgeons can be directly at odds with each other: “On the one hand we ask them to be steely and make life and death decisions. Then on the other hand we ask them to be empathic and all soft and fluffy with patients and

families" (P12). Expectations of surgeons from others were generally perceived as contributory to the pressure of exuding invulnerability. One participant spoke of sharing his experience of an AE during the live phase of SUPPORT, "And the response I had from one of the colleagues was, "But you're P11, you always cope with everything." You know? And I kind of felt, that's actually putting more pressure [on me], that's not helpful, is it?"

Subtheme 2.2 The shame and stigma around support-seeking – "There's something wrong with them for being so vulnerable... maybe they should go off and do psychiatry or something."

Likely arising as a direct byproduct of insights identified in Subtheme 1.1 about the surgical identity and expectations of surgeons is their fear of being seen as weak, incompetent or unable to cope if they declare themselves as needing support. Non-surgeon participants particularly felt this is a pervasive issue: "If you... look like you need a bit of emotional support, maybe you're not really cut out to be a surgeon. Maybe you should have another think" (P12). Some participants likened the perception of support-seeking to breaking an unwritten surgical rule: "The hidden curriculum is you have to be tough, you shouldn't need these kinds of supports and there's something wrong with you if you do" (P12). Similarly, in contrast to some of the views expressed in Subtheme 1.3, some participants expressed doubt as to the likelihood of surgeons' engagement with psychological support: "...saying, "Surgeons, come and get some support from psychology," I don't know if that quite works, because there's all of this stuff around the stigma..." (P2). It was clear overall from all participants that the stigma associated with support-seeking behaviour remains a key issue in surgical culture, and that there is a "...huge sense of shame and secrecy surrounding it still" (P5).

The difficulty in surgeons admitting to mistakes and the impact of this on support-seeking was prominent between, and likely compounded by, Subthemes 1.1 and 1.2. Firstly, there is a reticence to admit mistakes to oneself: "...we're better at it with patients but less so with ourselves" (P6). This may act as an important barrier to support-seeking, because

acknowledgement of the mistake (which is challenging) is a pre-requisite to asking for help: “The first step, I suppose, is, before you even access any kind of support, it’s actually admitting that you’ve got it wrong and done something wrong, and that can be difficult sometimes” (P4). Furthermore, as this participant went on to say, talking about it can make it even harder, because “...if you admit it to somebody else, it makes it a bit more real”. The emotional and psychological impact of accepting fallibility for surgeons was felt to be significant: “I think fear is huge. I think shame is another thing. I think loss of confidence and having to admit your failures or that you’re human and that can be very difficult” (P15).

Some participants expressed contrasting views that humility should be considered a desirable attribute in a surgeon. P8 challenged what may be outdated views of the perceived vulnerability: “...definitely, some people I know, maybe it’s our older generation, or previous one, they think it’s a sign of weakness, which it’s not actually, you have to be brave to open up”. This may imply a potential shift in surgical culture in which support-seeking is embraced rather than stigmatised and considered a normality rather than a vulnerability.

Subtheme 2.3: Generational cultural shifts – “I think most younger surgeons coming through are much more aware of a holistic approach to looking after ourselves.”

Following on from the changing perceptions identified in Subtheme 2.2, several participants reflected on evolving attitudes towards vulnerability, wellbeing and accessing support. While P1 felt there are “...some quite old-fashioned surgeons out there still who probably have an ego that won’t tolerate that kind of approaching support”, “...they are getting fewer by the year”. Other participants shared this emergent sense of cultural improvement: “My feeling is this generation is better than the previous one” (P11).

However, cultural change was identified as an ongoing area for targeted improvement: “We really need to work hard at it” (P11). There was also a collective sense from several participants that rather than a quick fix, cultural change of this scale would be a gradual process. One participant reflected that surgical practice in this context is as deeply-rooted as

the professional perceptions explored in Subtheme 2.1 (the pressure of professional identity), and therefore, "...it's going to be a slow process. This is something that, for years, people have worked in a particular way, and then this is actually a bit of a change in the culture, and that takes time" (P14). Encouragingly, some participants had a sense of improvement through the implementation of the project: "...we're seeing that already now within this first year of doing SUPPORT" (P4), which highlights the potential role peer support programmes may have in effecting cultural change.

Subtheme 2.4: The impact of SUPPORT on surgical culture – "Actually, this is how we do things around here."

Several participants felt they had noticed a shift in surgical culture which they attributed to the implementation of SUPPORT. This was perceived by some participants as having arisen through the indirect and largely unmeasured impact of the programme. One site team member reported their peer supporters "...had a lot of informal discussions but nobody that's actually said, "Yes, I'm going to come"" (P6). One participant gave an interesting example of the potential indirect cultural impact of SUPPORT in their organisation, when their psychology colleague who was involved in SUPPORT had been approached by a male-dominated surgical department to give a talk about sexual safety in the workplace. This participant highlighted cultural change as a key benefit of the implementation of SUPPORT: "...the other aspect which I think is important is the, not unintended consequence, but the cultural shift, which is more difficult to measure... other things are happening which means that people definitely know about this stuff" (P13).

Other participants reflected on their personal involvement in SUPPORT and how this had changed their views or behaviours, which may contribute to wider cultural change. Interestingly, a non-surgical participant felt their involvement "...dispelled some of my stereotypical ideas about what surgeons are and what they're not" (P2). One participant described feeling prompted to talk to a colleague in the immediate aftermath of a recent intra-operative AE: "...having thought about the SUPPORT process and everything, I

immediately asked him, “Can I have a word with you”? (P7). Some participants reflected on the existence of SUPPORT itself as being a declaration of the need to prioritise surgeon wellbeing which, in turn, signals a positive cultural shift: “There’s a much better recognition now, because of this. A lot of people now seem to know about it and understand its importance” (P6).

3.3. Theme 3: Barriers to Implementation

This theme explores the key barriers that participants identified through their experience of implementing SUPPORT. Though several of these were framed as practical barriers, they also revealed some important subtleties linking primarily to cultural considerations in Theme 2. This link is important in developing an understanding of the difficulties in introducing support programmes for surgeons.

Subtheme 3.1: Systemic lack of awareness and institutional integration – “Really? Surgeons need help? Support? Really? Why?”

The introductory quote above reflected P6’s first discussion about SUPPORT with senior managers, encapsulating the lack of recognition of the importance of supporting surgeons after AEs. However, despite initial misgivings, the positive response from surgeons “...was fed up the chain of management” (P6) which resulted in a gathering momentum. One participant experienced a comparatively flat refusal, describing attempts to garner institutional support as “...pushing against a closed door in our Trust, unfortunately” (P16). This participant felt that their institution’s lack of buy-in reflected a reactionary, rather than proactive, approach to wellbeing:

“They see things very much as bums on seats... until the impact is felt, and somebody is actually off long-term sick because of the impact of it, I don’t think they’d really consider the psychological needs of the surgeons at all”.

A lack of institutional awareness of the importance of supporting surgeons after AEs may have fed into another prominent element of this subtheme, which was lack of general

awareness of the programme itself. Although all participants described collective endeavours to promote the project within their institutions, "...a practical issue we find is just trying to make sure people know about it. We still haven't completely resolved that" (P13). This participant also identified some compounding factors such as their institution's "very complicated management structure" which made it difficult to raise awareness.

The gap between intention and integration, both systematically and culturally, is perhaps best articulated by P11, who had their first experience of an elective patient death during the live phase of the project but was not approached by their SUPPORT colleagues: "...three of us are signed up, and the other two didn't even ring me to ask me to ask me how I was... can you imagine that?" This suggests that supportive practice and behaviour is not yet enmeshed even between directly involved and interested parties, which may make the institutional lag unsurprising.

Subtheme 3.2: Site team lack of time – "I think I can spend more time on this, but I don't have time."

Lack of time on the part of the site teams was clearly and unanimously identified as a prominent barrier to the implementation of SUPPORT. Despite the clear strength of interest in the project in a self-selected, enthusiastic group: "We agreed that we really did feel quite strongly that this was something we wanted to do" (P16), numerous competing priorities meant "Unfortunately, it never quite got to the top of anyone's to-do list...." (P16). Overall, participants expressed an inability to dedicate time to SUPPORT, despite its obvious value. As summarised by P16: "It's still very clear to me that there is a need for a system such as SUPPORT and... that peer-to-peer support from other surgeons would be a very beneficial thing. It's just the practicalities of implementing it that have proven difficult for us".

A nuance arising from exploration of this subtheme was that although participants described objective time pressures, they felt personally responsible for the perceived inertia surrounding the 'launch' of the project. This may be related to the pressure of the surgical

identity explored in Subtheme 2.1. One participant described their "...guilt, about the fact that that money has come in, it was my idea to join in, and yet we haven't really properly launched it yet" (P9). This is an interesting reflection considering P9 was the only site team member with experience of providing peer support during the programme, who received positive feedback from a surgeon who had been absent for several months following an AE. Meaningfully, the surgeon in question had also returned to work and the operating theatre and attributed this to the support they received. This highlights the profound and internalised pressure experienced by surgeons, where even objective evidence of success may not mitigate perceptions of failure or guilt.

This subtheme is intrinsically linked to Subtheme 3.1. A lack of institutional recognition of the importance of the project likely compounded the time pressures through site team members' lack of protected time to drive the implementation. The reciprocal need for protected time was frequently referenced as a requirement for successful implementation, with several participants highlighting the need for a nominated person to have dedicated time to drive the project forward. Participants felt this would involve "...negotiations within Trusts and within departments about the time that's required and recognising that time in some way" (P4).

Subtheme 3.3: Peer support training – "I think a lot of it is, am I going to say the wrong thing?"

This subtheme encompasses the difficulties site teams encountered during the process of training peer supporters. In a similar vein to Subtheme 3.1, while the most cited issues are practical, some subtlety emerged in the discussion. The difficulties of scheduling were clearly and consistently articulated by participants: "...just getting all the interested parties in the same place at the same time for as long as it takes was quite challenging" (P6). Another practical challenge was staff turnover, which directly affected the cohort of peer supporters in some cases: "One of them who had been trained previously left, because they were on a year away from work" (P2). Some participants expressed concern about the impact of

turnover on sustainability of the programme: "...obviously, things will continuously change in an organisation. There will be new surgeons coming in, there will be surgeons leaving" (P4).

Although the practical challenges were prominent in this subtheme, lack of confidence in delivering peer support training was perceived as contributory. Participants expressed general concern about being appropriately qualified: "Feeling that we were adequately trained to provide the training to our colleagues, we were worried about" (P16). Others were more specific about surgeons' apprehension in delivering psychological first aid, in that if support "...does get a bit more into mental health, I think maybe that puts people off, that they don't feel it's their area and that they wouldn't feel qualified..." (P14). Some participants pointed out an interesting tension here: "...[surgeons] have difficult conversations all the time with patients ironically, don't we? But... for some reason, we're all a bit scared about saying the wrong thing or doing the wrong thing" (P13).

Certain participants felt the fear of delivering peer support training could only be overcome by doing it, and articulated the importance of not shying away in this context: "You learn by mistakes... you learn by experience. So, I think that the difficulty was, at the beginning, to try to understand how to do it" (P3). This may imply that a 'lower stakes' training model may be beneficial: "...the trick was to pick something that wasn't clinical because it meant that they could focus on the presence or absence of the skills only" (P12). Another link between subthemes arose here in the dual need for standardised, yet individualised, support (Subtheme 1.3). While participants expressed concern about SUPPORT feeling like a 'tick-box' exercise generally, there was perceived value in structure in the context of peer support training. This was felt to be of particular importance given the apprehension about delivering psychological support: "We're not trained counsellors so a lot of that was using the College resource which you all provided, which actually is really good" (P4).

Subtheme 3.4: Difficulty in identifying AEs, surgeons in need, and referral to SUPPORT –

"We're missing access to surgeons who really need us, somehow."

Several participants highlighted the challenges in identifying AEs and affected surgeons:

“The bit that's still really difficult that we haven't nailed is how to make sure that we get people who have had an incident, definitely offered the opportunity to use SUPPORT” (P13).

Some site team members reflected that efforts to involve themselves in institutional mechanisms for identification of AEs which, as a parallel to elements of Subtheme 3.1, were thwarted by competing clinical commitments:

“I have now been linked in on a Thursday... some sort of surgical directorate meeting, where they talk about things that haven't gone as well as they should do.... But, I operate on a Thursday, so I can guarantee I'm operating whenever the ping comes through to say the meeting has started” (P1).

None of the participants were aware of a robust mechanism of AE capture which would give certainty that surgeons potentially needing support could be identified. There were similarly differing views about appropriate referral to SUPPORT. Some participants took a uniform, opt-in approach: “We're doing fully self-referral at the moment” (P5). However, participants who felt this approach was most appropriate also reflected: “...when it comes to the self-referral bit, you know, how many people are actually going to write an email saying, “I need help with this”? That's just probably not going to happen very often at all” (P4). Some site teams adopted a combined approach by setting up dedicated e-mail addresses as well as proactively contacting affected surgeons if they were informed by word-of-mouth. Others pointed out the downsides of a mandated, opt-out approach: “...if it's compulsory, it affects that kind of trust relationship” (P11). P6 felt similarly that SUPPORT is not “...the sort of thing you can force on people. I'd hate to see it be a formal process where, if something goes wrong, you must be referred to it”. Despite personally recounting the benefits of discussion with a colleague after an AE in Subtheme 2.4, one participant felt particularly strongly against contacting an affected surgeon: “I think that would be patronising in my opinion” (P7). By contrast, referencing evidence about surgeons not seeking support, others

felt: “Actually, it’s on the supporters to be proactive...” and that ideally the offer of support would happen “...automatically without the surgeon involved having to instigate it...” (P15).

3.4. Theme 4: Facilitators to Implementation

This theme explores the key facilitators identified by participants in implementing SUPPORT. These ranged from the influence of senior site team members to institutional endorsement, practical infrastructure and collaboration with psychology colleagues. Many of these enablers directly mirrored or mitigated the barriers described in the previous theme, highlighting the importance of alignment between people, systems and cultural context.

Subtheme 4.1: Influence of site teams – “It’s important to have a role of responsibility.”

This subtheme emphasises the critical role of the involvement of well-connected, often senior, site team members, particularly in recruiting institutional backing of SUPPORT and actively driving the implementation of the programme: “...sharing this work with a very senior surgeon... has been really positive, because of their influence and connections” (P2).

Several participants had worked in their organisations for many years and felt this was beneficial in introducing the programme “Dare I say it, I think I had a bit of influence. Because I’m now 20 years at the Trust.... I think, generally, people know me.... And they know if they help me, I’ll help them” (P6). One interview participant was a clinical director and described the advantage of their position in gaining support for the project: “...it becomes a fait accompli. So, I went to the medical director first.... Because I work for him” (P13).

The other benefit of site team members having leadership and managerial roles was in the identification of AEs, which could in some organisations have mitigated against the challenges outlined in Subtheme 3.4. One participant described the benefits of their colleague’s role in this context “...[X] is an associate medical director who sits on the SIU panel and various other committees. So, they actually do get to hear about difficult situations that have occurred in the Trust” (P9). P10 also spoke of the potential benefits of holding

these roles in this respect: “So if you are at a little bit of senior management, you can see that, it’s called serious events... they have access on the computer”. Overall, through their seniority, reputation and connections, site teams in turn influenced another key facilitator, which was institutional support for the programme.

Subtheme 4.2 Institutional support – “Once it goes there... from the executive team, or higher levels, the medical director... from that point onwards it’s very easy.”

Incorporating directly reciprocal elements to Subtheme 3.2, this subtheme highlighted the importance of institutional endorsement in the implementation of SUPPORT. Crucially, the key aspect of this was that it translated to actionable support, resulting in tangible benefits such as funding for the project. Despite the initial reaction from senior leadership P6 described in Subtheme 3.2, it later became apparent “...they’re all very much behind it, you know? They coughed up the money, they’ve all been really supportive of it”. One participant also identified financial investment to perception of the programme’s importance: “I think the fact he has supported it means that it is seen to be valuable” (P12).

The power of this facilitator to implementation was articulated by P10: “...once it goes there... the medical director or chief executive level, then from that point onwards it’s very easy.” Another participant agreed “...if we have the Executive Team supporting this, that’s half the battle, really” (P11) and went on to compare their experience with P16’s, referenced in Subtheme 3.2: “Because that was one of the experiences, wasn’t it...? They’re finding [getting institutional support] difficult. So I think we are lucky, from that point of view, certainly, having good support”.

This subtheme also highlighted counter-examples to the lack of understanding as to the importance of supporting surgeons in the echelons of NHS management explored in Subtheme 3.2: “It’s not often you go to people with no funding, and an idea, and they’re as keen to do it, and do it quickly as they did in our hospital. It was amazing” (P13). This was echoed by P8, who described securing funding for the project after discussion with senior

leaders: “Not everybody would be willing to do that. But the medical director felt that this is something, that we need to show that we care for our doctors as well”.

Subtheme 4.3: Practical facilitators

This subtheme highlighted two key practical facilitators to the implementation of SUPPORT. The first of these was administrative support, the benefits of which were organisational as well as in promotion of the project and co-ordination of referrals. Participants spoke of the distinct advantages of this: “...trying to set up meetings, arranging sending out leaflets, making posters, setting up an e-mail has been incredibly easy” (P7). Several participants co-ordinated receipt of referrals in this way: “...that e-mail is looked at by an administrator, who then forwards on the emails to the three main SUPPORT-trained people” (P9). Importantly, lessening the administrative burden associated with implementing SUPPORT mitigated the challenges identified in Subtheme 3.1, allowing site teams use their time more effectively.

The second practical facilitator was the fact that SUPPORT was an RCS England-led initiative. The importance of this was not only in the structure the programme afforded but in its credibility: “...one of the best things is that just having the stamp of the Royal College on it is a very good start” (P10). This was felt to be linked to external perceptions of the programme’s value and in garnering institutional support: “I think having it led by the College has made a big difference to the impact, both from the surgeons’ perspective, but also the Trust’s perspective” (P4).

Subtheme 4.4: Integration with psychology – “We really benefit from having the psychology team involved.”

As the introductory quote from P13 demonstrates, support from, and collaboration with, psychology colleagues was a key facilitator to successful implementation to SUPPORT in organisations where this was possible. In addition to fostering productive working relationships, participants felt involvement from psychology colleagues added credibility to the programme: “It feels as though it has some science behind it” (P13), which may have

been a positive influence on external perceptions of its value. This was echoed by the other surgeon in the sample who was part of a mixed-model site team, who felt their colleague "...has just been really helpful in all the meetings, at giving... a lot of evidence and suggestions" (P5). Several participants identified the benefits of psychologists' unique insights in the context of peer support delivery, which included "...the psychology of trauma and what are the best interventions" (P12) and the ability to "...introduce deeper conversations around... things like risk management" (P2). Participants also identified the crucial role of psychologists in supporting the peer supporters, the importance of which was evident in one participant's experience of supporting a colleague: "I think I was losing as much sleep as they were... I was up at night, racking my brain, trying to work out what the best thing to do was" (P9).

The potential value of psychology input in delivering peer support was also identified by those in surgeon-specific SUPPORT teams. P4 described a colleague's positive experience of accessing psychology support as well as a view that involvement of psychologists may boost peer supporters' confidence in Subtheme 1.4. They also felt this could be a recommendation of the SUPPORT project: "...we think that as much as peer-to-peer surgeon support is useful, it needs to be backed up with some more formal psychological support as well".

4. Discussion

This study sought to explore surgeons' perceptions of the effectiveness of a peer support programme for surgeons after AEs, and to identify participants' experiences of barriers and facilitators to its implementation. The findings reveal a strong collective belief in the importance of SUPPORT as a formal, routine response to AEs, but highlights a persistent disconnect between conceptual endorsement and the practical, institutional and cultural challenges of implementation.

4.1. Theme 1: Importance of SUPPORT

Perhaps unsurprisingly given their recognition of the inevitability of AEs and acknowledgement of the uniqueness of surgeons' working lives, participants felt one of the most valuable aspects of SUPPORT was its role in normalisation of AEs occurring, surgeons' responses to AEs, and support-seeking. This is consistent with previous studies, which have identified the validation of affected surgeons' experiences (Fall et al. 2024) and the ability to talk to someone who has "been there" (El Hechi et al. 2019 p.932) as strengths of peer support programmes. The availability of support for surgeons in the aftermath of an AE was perceived to be of unanimous importance in this study. Some participants described this as an essential component of surgical practice that should be integrated in a way that mirrors the well-established pathway through which occupational injuries are managed in healthcare. Participants also felt, in accordance with background literature, that initiatives like SUPPORT address an important gap in surgical wellbeing culture. Indeed, in line with previous authors, "perhaps no other profession that demands elite-level performance has devoted so little to the wellbeing of its practitioners" (Yoo et al., 2017 p.1019). Wider recognition of the programme's importance was also perceived as contributory to obtaining institutional support (Subtheme 4.2), which was a key facilitator to implementation. This "creation of a sense of urgency" was also recognised by El Hechi et al. (2019 p.928) as a key step in the creation of a peer support programme.

The perceived necessity of SUPPORT was frequently linked by participants to the significance of the impact of adverse events on surgeons. Some participants implied this may sometimes be underestimated and acknowledged their own lack of awareness prior to their involvement in the project. The severity of the impact of AEs was often perceived to be because of the directness of the impact of a surgeon on the patient's outcome, which is consistent with published literature (Lander et al., 2009; Orri et al., 2015). Participants often referenced the evidence base around surgeons' lack of engagement with support structures (Turner et al., 2022) to justify the importance of the programme. It is perhaps unsurprising that data appears to confer legitimacy to initiatives such as SUPPORT among a group of data-driven practitioners like surgeons, who may feel more comfortable expressing their perception of its necessity in evidence-based terms, rather than with more emotional language.

Perhaps unsurprisingly, the evidence base behind peer support was also perceived to be important to participants in this study. A distinct advantage of the model was felt to be related to the supporter's unique understanding of the professional activities and responsibilities of surgeons: "talking to somebody who gets it... what it's like in the trenches day-to-day". The benefits of peer support identified in Subtheme 1.3 were also linked to other subthemes (1.1 – normalisation of responses to AEs; 2.2 – shame/stigma of support-seeking) as its existence challenges the cultural expectations that surgeons should suffer in silence. This is in line with Busch et al. (2021), who argue that the implementation of a second victim support programme is a powerful statement against blame culture and stigmatisation of mental health concerns. Importantly, the message to healthcare organisations is the need to prioritise personal and professional wellbeing, and that their employees are deserving of psychological support (Busch et al., 2021). Perhaps one of the most interesting aspects of this subtheme was in highlighting the need to navigate the tension between standardisation and personalisation in delivering support for surgeons after AEs. Participants described a desire for streamlined, credible processes while simultaneously recognising the need for

individualised, human-centred support. Some participants valued structured protocols and specifically the suggested checklist, while others feared this may come across as an impersonal “tick-box exercise”. This implies initiatives such as SUPPORT must balance predictability with flexibility, ensuring accessibility and consistency while remaining sensitive to the personal, relational nature of emotional support. This learning is likely translatable to any “second victim” support programme and highlights one of the advantages of undertaking qualitative research in this area which allows an appreciation of the associated nuance.

Although the merits of surgeons supporting each other were consistently identified, so too was the importance of peer supporters receiving some kind of formal training, to avoid the discussion being centred around the technical aspects of the AE. Participants suggested this could also be mitigated by ensuring a representative spread of supporters from different surgical specialties, although in some cases a discussion with a direct colleague was perceived to be helpful. The value of training being highlighted in our study echoes Fall et al.’s (2024) assertions that without it, surgeons may inadvertently perpetuate their colleagues’ silent suffering, by wanting to help but not knowing what to say.

While surgeons have not historically engaged with offerings of support not specific to surgeons (El Hechi et al., 2019), some participants in this study felt peer support could be delivered appropriately by non-surgeons, such as anaesthetists, who had insight into surgical work. This raises an interesting question as to how rigidly surgeon-specificity of peer support programmes should be adhered to and whether surgeons would be open to receiving support from other colleagues. This may be an especially relevant consideration given that some of the challenges in obtaining institutional support explored in Subtheme 3.1 were related to the surgeon-specific nature of the project. There was also some debate among participants as to whether peer support is best delivered by surgeons or psychologists. Some felt there may be occasions when a discussion with a psychologist may be more useful and highlighted some potential downsides of talking to a surgical colleague. Overall advantages of both approaches were identified, with some suggestion that a “hybrid

model” might be the most promising future direction. This supports the potential benefits of peer support in the literature in that supporters can act as a bridge between service users and mental health professionals (El Hechi et al., 2019; Watson, 2017).

4.2. Theme 2: Surgical Culture

Consideration of the cultural context into which SUPPORT has been introduced provided important insights for the integration of peer support programmes in surgery and may have wider implications to other healthcare settings. Scott et al. (2009) have identified six stages of the natural history of doctors who are second victims: 1) Chaos and accident response, 2) Intrusive reflections, 3) Restoring personal integrity, 4) Enduring the inquisition, 5) Obtaining emotional first aid and 6) Moving on. They propose that the final stage results in three potential outcomes: quitting, surviving or thriving. Luu et al. (2012) describe a similar four-stage process: 1) The kick, 2) The fall, 3) The recovery and 4) The long-term impact. Surgical culture is reliably cited as a clear barrier to support-seeking (Scrimgeour & Turner, 2024), which Fall et al. (2024) specifically contend does not facilitate productive movement through these phases.

Even in a self-selecting group of interested and informed participants, all of whom unanimously endorsed SUPPORT on an intellectual level, there was a sense of the enduring grip of the surgical identity and the “hidden curriculum” that demands surgeons are tough, and that support-seeking is a sign of weakness. This provides a compelling explanation for the persistence of stigma and possible reticence around SUPPORT. The internalised surgical norms of stoicism, infallibility and self-sufficiency are not easily dislodged, which was also evident in Subtheme 3.2 (site team lack of time), where participants described guilt about their inability to drive the project whilst acknowledging an objective lack of time to do so.

However, there is an interesting tension between the power of the “hidden curriculum” in reinforcing silence and avoidance after AEs with the emergent sense from Subtheme 1.1

(normalisation of AEs, reactions and support-seeking) that surgeons' recovery after an AE is crucial to maintaining their sense of professionalism, patient safety and effective team-working. This is a useful insight, as whilst previous work has highlighted the lack of support-seeking in surgeons (Scrimgeour & Turner, 2024), our study helps identify the fundamental challenge of surgical culture and attitudes around support-seeking as a barrier to peer support programmes. While our study suggests the potential for a shift in focus on surgeon wellbeing from desirable to essential, the implication in this subtheme is that changing behaviour will require addressing the cultural inputs that inform the surgical identity, including the values taught during training which are likely reinforced through contemporary leadership.

There was an acknowledgement among participants that this change may already be taking place. Participants described a hopeful, albeit gradual, cultural shift, in that newer generations of surgeons are perceived as more open to vulnerability and support-seeking, which may reflect broader societal changes in attitudes to mental health and wellbeing (Mind, 2024). The findings in this study also highlight SUPPORT's potential role in wider cultural transformation. This was strongly linked to role of the programme in the normalisation of AEs, their emotional aftermath and help-seeking behaviour. This echoes findings of El Hechi et al.'s (2019) work, in which 81% of survey respondents indicated the peer support programme positively impacted the departmental "safety and support" culture through raising awareness of the need to support surgeons in times of difficulty (p.931).

This is an important challenge to the pervasive shame and stigma explored in Subtheme 2.2, where support-seeking is felt to be culturally transgressive: "maybe you're not really cut out to be a surgeon". The impact of SUPPORT on surgical culture was deemed to be paced similarly to the generational changes also described in this subtheme. Participants perceived an indirect influence of the project on attitudes and behaviours, and in prompting broader conversations around sexual safety and psychological wellbeing, observations mirrored in Fall et al.'s (2024) study; although most trained peer supporters had not been asked to

provide support through the APSA programme, 80% reported they had used the skills in informal settings. This is also reflected in broader systems-level theories of organisational change, where the concept of structural and environmental inertia has long been recognised, against which small, incremental interventions can still generate meaningful change (Hannan & Freeman, 1984). Overall Themes 1 and 2 suggest that SUPPORT is perceived as more than a reactive tool, and could be considered a cultural intervention, through which normalisation should be a strategic goal, rather than a fortuitous byproduct.

4.3. Theme 3: Barriers to Implementation

This theme identified several practical challenges but also revealed interesting underlying and contributory factors. For example, lack of institutional support was a clear barrier, which seems to be related to the lack of awareness about the need to support surgeons. This may in turn be secondary to traditional expectations of surgeons outlined in Subtheme 2.1 (pressure of professional identity). Similarly, difficulties in delivering peer support were in part due to logistical challenges, but participants revealed the underlying cause for the relative inertia was under-confidence. This highlights one of the profound benefits of qualitative research in this area, which may capture nuance beyond surface-level (Lim, 2024).

Subtheme 3.4 highlighted the difficulty in identifying AEs, affected surgeons, and in initiating appropriate support. Several participants had suggestions as to how AEs might be captured but described a probable over-reliance on “word of mouth”. This study potentially exposes a critical systemic weakness in that no institution had a robust mechanism for identification of AEs such that site teams were guaranteed to be notified. This contrasts with the approach of El Hechi et al. (2019), who outlined several means of doing so. Self-referral was the most common means of access to SUPPORT, but the limitations were clear: not only does this depend on individual impetus (grounded amongst other things in self-awareness and willingness to admit to fallibility), but the ability to overcome the cultural barriers explored in Subtheme 2.2. Referrals to the APSA programme were through self-referral or referral by others, and all of those referred accepted the offer of support (Fall et al., 2024). However, it

is unknown whether those who did not self-refer had asked to be referred or were consulted, or were unaware, the latter of which would be closer to an opt-out approach.

Meanwhile, in this study, overly formalised opt-out systems were perceived by some as intrusive or “patronising”. However, placing the onus on an affected surgeon to access support in the aftermath as AE has been identified as a potential barrier (Scrimgeour & Turner, 2024) and in a large group of American paediatric surgeons, only 11% indicated they did not wish to be contacted after an AE (Berman et al., 2021). Perhaps unsurprisingly some participants in this study felt strongly that surgeons should be contacted after an AE and that this is a key role of the peer supporter. This may be supported by results of El Hechi et al. (2019), who used an opt-out method of referral, and found that only 19% of surgeons declined the offer of support. This is also reflected more widely by experts’ recommendations that peer support should be offered after AEs using a “push” rather than “pull” strategy, in recognition of the well-established barriers to support-seeking in healthcare (Shapiro, 2020). The tension identified in this subtheme suggests the need for institutionally-based identification methods for AEs, after which the offer of support is made proactively yet discreetly. SUPPORT may benefit from integration into existing clinical governance or incident reporting processes and providing peer supporters with clear pathways for appropriately gentle outreach. However, this again exemplifies the challenges discussed in Subtheme 1.3 in delivering a support system which is standardised yet bespoke.

The central tension arising in this theme was the striking contrast between the strong belief in the necessity of SUPPORT emerging in Theme 1 and the persistent barriers to its operational uptake. Participants repeatedly emphasised the inevitability of AEs and the profound emotional and psychological toll they can take, reinforcing the legitimacy of SUPPORT as a structural response. This aligns with the evidence base not only about the impact of AEs on surgeons (Turner et al., 2022), but also more widely the international recognition of the “second victim” phenomenon in healthcare and the moral imperative to support affected clinicians (Wu, 2000). However, even in those engaged with SUPPORT,

there was a disconnect between belief and behaviour, perhaps most poignantly highlighted by P11, whose colleagues also involved in the project did not contact them after they personally experienced an AE.

This mirrors findings from research in primary care about the persistence of tacit, collectively reinforced norms – referred to as “mindlines” – despite relevant knowledge and availability of formal structures (Gabbay & le May, 2004). In this study, clinicians seldom accessed evidence from research or other sources to inform clinical decision-making. Instead, they relied on “mindlines” informed mainly by their own and colleagues’ experiences and interactions with each other. This highlights an important practical consideration for the design of SUPPORT. A benefit of the QI model is that it empowers clinicians to drive and develop initiatives within their local context. However, there may for example be an argument to centralise training and provide a greater breadth of resources, especially given the barriers identified in terms of participants’ time constraints and organisation of peer support training. This ‘didactic’ model would be more closely aligned with the delivery of existing surgeon-specific peer support programmes (El Hechi et al., 2019; Fall et al., 2024). There is also a broader implication for implementation strategies. These must account not only for logistical barriers but also for entrenched cultural scripts, which may constrain action irrespective of the strength of intention, as has long been recognised in organisational change literature (Burnes, 1991; Michalak, 2010).

4.4. Theme 4: Facilitators to Implementation

Several well-defined facilitators were identified in this analysis, some of which were (perhaps unsurprisingly) directly reciprocal to the barriers in the previous theme. Influence of the site teams, generally through seniority and/or being in positions of responsibility, was integral to recruiting institutional support. This was identified as a key aspect in the first step of the process of designing a peer support programme by El Hechi et al. (2019). In the present study the importance of institutional buy-in was that transcended conceptual support, resulting in tangible outcomes such as funding for the project. Site teams’ managerial roles

may also have mitigated against the challenges explored in Subtheme 3.4 in identification of adverse events and affected surgeons, as they may be more likely to be notified through institutional mechanisms. This is supported by recommendations of experts in the field of peer support programmes (Shapiro 2020), who have identified the interface between institutional processes and these initiatives as critical to success.

Overall, the influence of site teams and institutional support emerged as powerful facilitators. Where SUPPORT had the backing from senior leaders it appeared to gain legitimacy, visibility and traction, which is in line with Hu et al.'s (2012) conclusions about the importance of visible commitment from leadership to successful implementation. Conversely, in Trusts where this was not the case, efforts were stymied no matter the enthusiasm from the site team. This suggests strategic alignment with executive leadership, including framing SUPPORT as a workforce retention and risk management strategy, may be integral to sustainability. There were also clear practical facilitators such as the availability of administrative support and the “stamp” of RCS England, which was felt to be important in obtaining institutional backing.

Integration with psychology colleagues was identified as a key facilitator to successful implementation of SUPPORT. Participants felt psychologists' expertise brought credibility to the programme and was critical in providing support for peer supporters. One participant felt involvement of psychologists could be a recommended outcome of SUPPORT, which they feel “needs to be backed up with some more formal psychological support”. This may be similar to the three-tiered model proposed by El Hechi et al. (2019), where peer support is intended to bridge the gap between informal support from colleagues and formal psychological support. The benefits of involvement of psychologists emerged in both Subthemes 4.4 and 1.3, suggesting initiatives such as SUPPORT may best function if they are peer-delivered but psychologically informed.

4.5. Strengths and Limitations

Overall this is novel work which could help to inform the successful delivery of peer support for surgeons after AEs in the UK. The strengths of this study are in providing a qualitative narrative to the implementation of surgeon-specific peer support programmes, which has insofar been lacking in the literature. This is the first study of its kind and is especially relevant considering other similar endeavours are all USA-based. Accepting that most participants were surgeons, non-surgeons were over-represented in this sample, which has provided depth and breadth of perspectives across professional roles. A relatively large sample of possible participants (representing ten out of twelve sites) were interviewed, using an established and in-depth analysis technique. The researcher's role as a surgeon helped with recruitment, rapport and potentially the understanding of participant experiences.

Limitations of this study may include selection bias, in that interviewees may have comprised a self-selecting group, who were likely more interested and engaged in the project than the average participant. Thus, this study does not give a clear picture of the experiences and attitudes of surgeons more broadly in the UK, who have not 'bought in' to the SUPPORT initiative. Moreover, although this work provides rich insights into the experiences of site team members in setting up a peer support programme, it does not focus on the experiences of supported surgeons. Arguably their voices are integral in understanding the true effectiveness of SUPPORT and the potential value of peer support conversations within hospital Trusts.

Due to the set-up of this study, participants may also show social desirability bias, and their responses may reflect a particular timepoint in the implementation of SUPPORT. Firstly, data collection was not entirely separate from SUPPORT, as the researcher was part of the project team, and participants may not have felt able to be completely honest about potentially negative feedback. Secondly, the interviews took place in the project's infancy, and some of the early challenges may have improved or resolved, particularly as it is recognised successful implementation is likely part of a gradual cultural change. Finally,

perceptions are dynamic, so whilst participants' responses may have been representative during the data collection period, results may have been different had this been completed at another time. Future work may therefore benefit from following up with participants once SUPPORT has been better established in their organisations, and in considering the potential usefulness of interviews carried out by a researcher separate from the SUPPORT team.

4.6. Future Directions

While this study is useful in providing insights into the experiences of implementing a peer support programme for surgeons after AEs, much more data is needed from surgeons supported through this initiative and others. Additionally, researchers would benefit enormously from hearing from surgeons who do not access support, even when it is available (and they are aware). At present, only limited quantitative data is available about proportions of surgeons who accepted or declined support. Some surgeons may have access to alternative means of appropriate support after AEs. However, others may feel unable to access it for the cultural barriers identified, or because they do not feel the peer support model is useful or effective. Understanding this will be critical to shaping future endeavours.

Finally, given the power of evidence as a lever for change, particularly in the surgical world, more data is needed as to the effectiveness of these programmes in driving change not only for individual surgeons but more broadly in surgical culture. While there is some initial promising data from small scale USA studies (e.g. El Hechi et al., 2019), to date there are no published effectiveness data for peer support programmes in the UK, and robust quantitative longitudinal or organisational data is also lacking in this area. Such data would be hugely important in understanding the usefulness of peer support in terms of organisational change, support-seeking and satisfaction with peer support conversations, now that we have a clearer insight into the qualitative experiences of programme implementation.

4.7. Conclusions

Peer support for surgeons is perceived not only as legitimate but necessary by surgical and non-surgical professionals alike. However, successful implementation requires more than belief – it needs deliberate cultural, institutional and logistical embedding. Surgical culture remains a barrier to and target for change, despite the breadth of evidence as to the profound impact of AEs on surgeons. SUPPORT has the potential as a mechanism to normalise AEs, surgeons' responses in the aftermath and support-seeking, and in doing so, to enhance recovery after AEs and (slowly) contribute to cultural change. To fulfil this, it must be designed and resourced in ways that are adaptive, trusted and institutionally endorsed. Only then will support after AEs be recognised not just as an aspirational, benevolent phenomenon, but as a routine and essential part of surgical infrastructure.

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6. Appendices

Appendix A

E-mail advert



SUPPORT001
Ethics ID: 60068
Date: 11/10/2024

Dear Colleague

We are looking for SUPPORT project site team members willing to take part in a 60-90 minute interview to help us evaluate the project and to learn from your honest experiences of being involved!

We are inviting you to take part in an interview to help us evaluate the Surgeon Peer-Led Post-Incidence Response Teams (SUPPORT) peer-support initiative for surgeons which has been rolled out at your hospital site.

Your hospital is taking part in the SUPPORT Improvement Collaborative which aims to improve peer support following adverse events in surgery. An evaluation of this collaborative is being carried out by researchers and clinicians at Bournemouth University (BU) in collaboration with the Royal College of Surgeons of England (RCS England).

As part of this evaluation, we are hoping for SUPPORT project site team members to answer some questions about their experience of participating in the project. This will allow us to develop a richer understanding of things that have facilitated or acted as barriers to its implementation and will help us to shape the next iteration of SUPPORT. It is very important for our team to understand if the SUPPORT collaboration is helping surgeons, and we would greatly appreciate your input.

For more information and to take part, please contact Gemma Scrimgeour: gscrimgeour@rcseng.ac.uk.

Many thanks for your time.

Best wishes

Miss Gemma Scrimgeour

Specialist Registrar in Urological Surgery/RCS England Innovation and Improvement Fellow/Postgraduate Researcher

(on behalf of the RCS England SUPPORT Improvement Collaborative and the BU Surgeon Wellbeing Research Team)

Appendix B

Participant Information Sheet (PIS)



SUPPORT002
Ethics ID: 60068
Date:10/12/2024

Participant Information Sheet

The title of the research project

Experiences of implementing a peer-support programme for surgeons after adverse events

Bournemouth University (BU) Surgeon Wellbeing Research Team

This research project is led by Miss Gemma Scrimgeour, Specialist Registrar in Urological Surgery/Postgraduate Researcher, on behalf of the BU Surgeon Wellbeing Research Team, in collaboration with the Royal College of Surgeons of England (RCS England).

What is the purpose of the project?

We are evaluating the Surgeon Peer-led Post-incident Response Teams (SUPPORT) Improvement Collaborative, launched by RCS England in January 2024 in collaboration with BU. The SUPPORT Improvement Collaborative aims to help 12 hospital Trusts in the UK and across Ireland to design, deliver, sustain and evaluate a peer-support programme to support surgeons following experiences of adverse events.

Why have I been invited?

You have been invited because you are a member of the site team at one of the Trusts participating in the SUPPORT Improvement Collaborative. As part of our evaluation of the project, we would like to gain a richer understanding of participants' experiences of being involved with SUPPORT than is possible through analysis of survey-based data alone. We are aiming to recruit around 10 site team members. Talking to SUPPORT site team members will give us valuable insights into the experience of implementing the SUPPORT project, and crucially of facilitators and barriers to its delivery. It would be incredibly valuable for us to hear and learn from site team members' honest feedback about what worked and what didn't, to inform future iterations of the project.

Do I have to take part?

Your participation is entirely voluntary, so take your time to decide whether or not you would like to take part. Your decision about whether to take part or not will not affect your relationship with the SUPPORT project team or with RCS England. If you decide to take part we will ask you to complete an online consent form before the interview. You can however change your mind and withdraw at any time, in which case we will not collect any further information from or about you.

Appendix C

Participant Agreement Form



SUPPORT001
Ethics ID: 60068
Date: 11/10/2024

Participant Agreement Form

Full title of project: ("the Project") Experiences of implementing a peer-support programme for surgeons after adverse events

Name, position and contact details of researcher: Miss Gemma Scrimgeour, Specialist Registrar in Urological Surgery/RCS Innovation and Improvement Fellow/Postgraduate Researcher, Bournemouth University, gscrimgeour@rcseng.ac.uk

Name, position and contact details of supervisor: Dr Maddy Greville-Harris, Clinical Psychologist and Senior Lecturer in Psychology, Bournemouth University, mgrevilleharris@bournemouth.ac.uk

To be completed prior to data collection activity

Section A: Agreement to participate in the study

You should only agree to participate in the study if you agree with all of the statements in this table and accept that participating will involve the listed activities.

I have read and understood the Participant Information Sheet (SUPPORT002) and have been given access to the BU Research Participant Privacy Notice which sets out how we collect and use personal information (https://www1.bournemouth.ac.uk/about/governance/access-information/data-protection-privacy).	
I have had an opportunity to ask questions.	
I understand that my participation is voluntary. I can stop participating in research activities at any time without giving a reason and I am free to decline to answer any question(s).	
I understand that taking part in the research will include the following activity/activities as part of the research:	
• taking part in an interview • being audio recorded during the project • my words will be quoted in publications, reports, web pages and other research outputs without using my real name	
I understand that, if I withdraw from the study, I will also be able to withdraw my data from further use in the study except where my data has been anonymised (as I cannot be identified) or it will be harmful to the project to have my data removed.	
I understand that my data may be included in an anonymised form within a dataset to be archived at an appropriate research data repository such as BORDaR (BU's Data Repository).	
I consent to take part in the project on the basis set out above (Section A) – please type your name here to indicate your consent.	

Appendix D

Interview schedule

Note: this is an indicative guide of the types of topics that will be covered and questions that will be asked in the semi-structured interviews.

Opening

Thank you for participating in this research. The purpose of this project is to evaluate the Surgeon Peer-led Post-incident Response Teams (SUPPORT) Improvement Collaborative, launched by RCS England in January 2024 in collaboration with Bournemouth University (BU). As part of our evaluation, we are carrying out interviews with members of the SUPPORT project team at participating sites. These interviews will give us a valuable opportunity to learn about your experience of and honest feedback about being involved with SUPPORT.

Your participation is entirely voluntary, and you can withdraw from the interview at any time. You do not have to answer any question or questions you don't wish to answer. You have already signed an online consent form, but before we begin, can I confirm you are still happy to take part in the interview?

This interview will be recorded. The audio recordings will be stored on a password-protected computer and will only be accessible to the research team and professional transcription service. Recordings will be deleted as soon as they have been transcribed. Our data will be analysed by collating all interview responses and identifying broad recurring themes. You will not be able to be identified in any external reports or publications about the research.

Before we start, is there anything you would like to ask or clarify? I will begin the audio recording now.

Interview

Could you tell me a bit about your current role? For example, how long have you been doing it?

What are your thoughts about the importance of supporting surgeons after adverse events?

What do you think supporting surgeons after adverse events should look like?

What are your thoughts about what it should look like for trainees?

What do you think the barriers to accessing support are?

Follow-up: what about Could you tell me about what made you want to be involved with the SUPPORT project?

for trainees?

What do you think the experience

What do you think of surgeon-led peer support as a model?

Follow-up: could you tell me about alternative support models that could be effective?

Could you tell me about what made you want to be involved with the SUPPORT project?

Before you signed up to the SUPPORT Improvement Collaborative, what did supporting surgeons after adverse events look like in your Trust?

Follow-up if Trust had existing support mechanism e.g. what has been tried in the past, was this effective?

Could you tell me a bit about how your organisation prioritises support for surgeons after adverse events?

Follow-up if not the case e.g. could you tell me a bit more about that?

Can you tell me about SUPPORT in your organisation?

How do you find out about adverse events?

How are surgeons referred?

How would you describe your role in the SUPPORT project?

Who else is involved?

How would you describe the implementation of SUPPORT in your organisation?

Could you tell me about things that have gone well?

What do you think has facilitated this?

What have the challenges been?

Follow-up questions/prompts depending on responses to do with different stages:

What has worked well/less well in terms of creating a SUPPORT team?

Advertising/publicising SUPPORT?

Training peer supporters?

Initiating/uptake of SUPPORT conversations?

Facilitators/barriers to changing uptake/culture

Evaluation?

Sustainability?

How would you describe the support available to surgeons after adverse events in your organisation now?

Can you tell me about the experience of being part of the SUPPORT collaborative?

What aspects of being involved in the collaborative have been useful?

What aspects have not been useful?

What would you change about the SUPPORT project?

For the final question, what could we improve for SUPPORT 2?

Is there anything else that we haven't touched on that you would like to talk about?

Do you have any questions?

Closing

Thank you very much for giving up your time to participate in this research. We will be sending you a debrief document by email, but please do get in touch if you have any further questions or concerns. Unless you have any questions at this point or there is anything else you would like to discuss, I will stop recording now.

Appendix E

Ethics checklist



Research Ethics Checklist

About Your Checklist	
Ethics ID	60068
Date Created	10/10/2024 20:11:23
Status	Approved
Date Approved	17/12/2024 14:53:19
Risk	High

Researcher Details	
Name	Gemma Scrimgeour
Faculty	Faculty of Science & Technology
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, EngD, EdD)
Course	Postgraduate Research - FST
Have you received funding to support this research project?	No
Please list any persons or institutions that you will be conducting joint research with, both internal to BU as well as external collaborators.	Royal College of Surgeons of England (hereafter referred to as RCS England)

Project Details	
Title	Experiences of implementing a peer-support programme for surgeons after adverse events
Start Date of Project	23/09/2024
End Date of Project	30/06/2025
Proposed Start Date of Data Collection	01/01/2025
Original Supervisor	Maddy Greville-Harris
Approver	Research Ethics Panel
Summary - no more than 600 words (including detail on background methodology, sample, outcomes, etc.)	

Appendix F

Resources for SUPPORT participants

	Video of 5.1 PS training The conversation...		29/08/2024 15:59	File folder	
	Video of 6. PS Supporting the supporters		29/08/2024 15:59	File folder	
	1.1 PS training Need and Aims of the SUP...		17/06/2024 08:19	Microsoft PowerP...	4,079 KB
	1.2 The psychology behind peer SUPPORT		06/03/2024 10:28	Microsoft PowerP...	13,056 KB
	2. PS training Whats available currently		25/02/2024 14:36	Microsoft PowerP...	1,780 KB
	3. PS training Overview of SUPPORT prog...		28/02/2024 18:25	Microsoft PowerP...	2,144 KB
	4. PS training Key qualities of a PS		25/02/2024 14:36	Microsoft PowerP...	2,025 KB
	5.1 PS training The conversation and che...		17/06/2024 09:13	Microsoft PowerP...	4,679 KB
	5.2 PS training The conversation - trauma...		01/03/2024 13:01	Microsoft PowerP...	2,498 KB
	5.3 PS training The conversation - psych r...		01/03/2024 13:04	Microsoft PowerP...	2,519 KB
	6. PS Supporting the supporters		25/02/2024 14:37	Microsoft PowerP...	10,062 KB
	7. PS training Promoting the programme		25/02/2024 14:37	Microsoft PowerP...	1,179 KB
	8. PS training Evaluating and refining		25/02/2024 14:37	Microsoft PowerP...	2,542 KB
	CST Reference Form 2 Prof. Walsh 2		02/07/2024 18:39	Microsoft Word D...	4,870 KB
	Leaflet - Managing Psychological Risk		25/02/2024 14:37	Microsoft Word D...	327 KB
	Leaflet - Who makes a good Peer SUPPO...		29/02/2024 15:53	Microsoft Word D...	102 KB
	Leaflet-Your wellbeing as a SUPPORTer		25/02/2024 14:37	Microsoft Word D...	102 KB
	Overview of training resources for PS - 8 ...		24/05/2024 14:25	Microsoft PowerP...	1,869 KB
	PS Conversation Checklist		01/03/2024 09:11	Microsoft Word D...	105 KB

Appendix G

Example thematic table

Theme	Subtheme	Definition and links	Quotes
Facilitators	Institutional support	A reciprocal subtheme to 'lack of institutional support' – the interest here is that it is possible to map those who reported good institutional support against objective progress which confirms this is important. One particular tension from someone who involved someone from management in peer support team and was criticised for doing so (P11)	"So, the trust has been very supportive." P1 "Well, it paid for the 10 grand to go on the course, and it has allowed me to do the training." P1 "And I think they have been reasonably supportive about it." P1 "But, certainly, no one has been obstructive with it." P1 "But as long as the people that need to know about it, know about it, so like the clinical directors, like the clinical governance leads, at departmental level and at Trust level as well, as long as they know that this programme exists and that we should use it, then I think that's usually good enough." P4 "I think the fact that the hospital charity was willing to fund it, that was great." P4 "But, actually, they leapt at it, as soon as I raised it, so that was easy. So, actually, persuading the board to be behind it was easy." P6 "I don't think there have been any challenges with supporting the organisation, they're all very much behind it, you know? They coughed up the money, they've all been really supportive of it." P6 "I don't know whether you're aware, we were the first ones in our trust who actually arranged a training session doing the whole group and we were all set to make a video and all these things. It was very easy because we had a member of the HR admin team, managerial team supporting us, X, who was quite good, and that way, the emails which we have made, the email for SUPPORT, she'll pick up that email as well." P7 "So, we've had buy-in from the managers, we've had the payment." P1 "And once it goes there, I think from the executive team, or higher levels, the medical director or chief executive level, then from that point onwards it's very easy." P10 "Yeah, I suppose the Medical Director was very supportive. She sent an email to everybody, saying how good it is and we need to do that." P11