PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	The kindness COVID-19 toolkit: a mixed methods evaluation of a program designed by doctors in training for doctors in training
AUTHORS	Ward, Madeleine; Crinall, Karen; McDonald, Rebecca; Crinall, William; Aridas, James; Leung, Cheryl; Quittner, Danielle; Hodges, Ryan J; Rolnik, Daniel

VERSION 1 – REVIEW

REVIEWER	Rich, Antonia University College London Medical School, Research Department of Medical Education
REVIEW RETURNED	28-Feb-2022

GENERAL COMMENTS	Thank you for sending me this paper to review. This is an important topic and the authors have rightly pointed out some of the statistics that show wellbeing support to doctors in training is urgently needed. I have some suggestions to improve the manuscript. Concerning the qualitative analysis, the write-up in the results in rather short - 5 themes are presented but only one sentence is given to each theme and then one brief quote to support it. I would like to have more information about the theme and more supporting quotes – these could be in appendix if word count is an issue. Concerning the quantitative analysis, the paper states that 17 trainees attended at least one of the workshops (page 7) - does that mean 38 trainees didn't attend any of the workshops? If so, this should be clearly stated. From the title of the paper I assumed that it was an evaluation of the workshops but if so few attended then it is more about evaluation of the toolkit? If so, I think the paper title needs to change and the structure of the method so that the intervention is more about the toolkit, and less so the workshops. It would also be helpful to comment on why attendance at the workshops was so poor. Apologies if I have misunderstood and workshop attendance was much higher.

REVIEWER	Acton, Jade King Edward Memorial Hospital for Women Perth
REVIEW RETURNED	27-May-2022

GENERAL COMMENTS	Thank you for a well designed and written paper. What a lovely intervention with promising results. I have only minor reviews: 1. Page 4, line 24 - spelling 'loosing' should be 'losing' 2. page 10, line 41: Communication - can you give a free text example?

	3. Limitations: I feel the response rate and how this may include bias needs to be discussed. Did people who felt a positive outcome feel more likely to respond. If people are feeling disengaged would they want to fill out surveys on their wellbeing?

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	
Concerning the qualitative analysis, the write-up in the results in rather short - 5 themes are presented but only one sentence is given to each theme and then one brief quote to support it. I would like to have more information about the theme and more supporting quotes – these could be in appendix if word count is an issue.	Thank you for highlighting the need for further data to be included from the qualitative analysis. We have taken on your recommendations and included the 'most significant stories' as an appendix and expanded the information included in the thematic analysis to include more detail on the program and the impacts on the doctor trainees. We have also referenced the publications which further describe the qualitative analysis, both the Most Significant Change evaluation report provided by the external consultants, and an academic publication with a focus on the qualitative component of the study. Page 11, Lines 14 to 16 now read: "The complete methodology and outcomes of the qualitative analysis have been published elsewhere, below we list a summary of the findings." Page 11, Line 51 to Page 13 Line 36 now read: "Connection: Connections between DiT were strengthened through the P2P learning model of the workshop design, with one participant reflecting that "hearing others talk about their experiences and feelings of not being okay and sharing my experiences and feelings…made me feel more connected and less alone". Another participant observed: "One of the most important things to come out of the program during the pandemic was being closer to colleagues that I don't work with every day". A participant story described a significant change for them as "a noticeable physical difference…the revamp of our doctors' office, there is new furniture, and plants in there now, it is fresh and more open. We feel welcome; now I've somewhere that I belong at work". Communication played an important role in fortifying connections. The impact of the workshop session which explored 'Esteem' was recalled as motivating DiT to connect with one another by engaging in two-way feedback. An example of how this was enacted was explained by one participant as paying attention to asking others "about their shift, and how they felt they went, and…ask[ing] them for feedback on how they thought I had gone". Caring: Caring emerged as a significant change. Participants recognised "a more organised sense of looking out for each other". The workshop on meeting basic needs, in particular, shifted how DiT thought about self-care, as well as encouraging greater care for each other. Participants explained that "people were asking, 'Have you had water this morning? Have you had enough to eat?'". They also reflected "the program reminded us to take care of ourselves, and to suport each other, even on long shifts when we are very stressed at work". Another observed: "Overall, the general culture at work has changed, everyone is more mindful of each other's wellbeing." Communication: The program offered alternative ways to share information and opened up communication vertically and horizontally. Investing in the revamping of the doctor's office space was experienced as a powerful gesture by participants. The program was described as having

	created a “space to talk” allowing trainee doctors to “hear each other”. Another participant explained, “The workshop on giving feedback; asking for feedback and how to give feedback in a constructive, rather than critical way, I took that on. I will definitely remember that in the future. The workshop normalised open conversation”. Others observed an increase in interactions with colleagues, More open communication facilitated supporting each other, “When I spoke about what I was going through, others then asked me for a coffee or a meal and shared their version of not being okay.” Confidence: All participants felt more confident as a result of experiencing the program. They were not only more confident about asking for help, they also felt empowered to be leaders and bring about change. One DiT reflected that they had “learnt that courage is not the absence of fear – it is the ability to act in the presence of fear”. Another explained that for them the “most important change brought about by the wellbeing program…was recognising my agency. I learned there were changes I could make.” The peer to peer delivery was highlighted as a major contributor to program impact, with one participant observing “a highlight was senior clinicians telling their own stories. You can have grandiose ideas about others at work, especially the seniors you admire, how they know everything and do everything right. Witnessing their fears and concerns, and their approaches to challenges makes you more impressed by their achievement, you feel like challenges are more approachable, the steps ahead are more attainable”. Cooperation: The program aimed to bring O&G DiT together; to reflect, learn and grow skills to improve wellbeing, and most importantly to have their concerns acknowledged and acted upon at an organisational level. Participants of the program observed a shift to more cooperative workplace practices, reporting that “the program was also an opportunity to address the things that make a cohesive team, that make us all better together. More than before the whole team stepped up to help each other make it through the day together.””
Concerning the quantitative analysis, the paper states that 17 trainees attended at least one of the workshops (page 7) - does that mean 38 trainees didn’t attend any of the workshops? If so, this should be clearly stated. From the title of the paper I assumed that it was an evaluation of the workshops but if so few attended then it is more about evaluation of the toolkit? If so, I think the paper title needs to change and the structure of the method so that the intervention is more about the toolkit, and less so the workshops. It would also be helpful to comment on why attendance at the workshops was so poor.	Thank you for your comment. You are correct the workshops were one of the ‘tools’ nested within the program. We have therefore followed your recommendation and altered the title to include program rather than workshop. We have also added a section to the results listing the elements of the program as well as clarifying in the participant section that it is not known how many viewed the recordings. Page 10, Lines 28 to 41 now read: -“ ***Program overview*** The program, which was evaluated as a whole rather than the individual components, included; seven one hour live remote workshops (covering each of the six themes and one review session); circulated recordings of the workshops; three online social sessions; a hydration station stocked with drinks for each work site; six laminated wall posters with the main concepts from the workshops posted at each work site; a senior trainee education session on supporting junior trainees; a meeting with senior management advocating for wellbeing initiatives; a business proposal for a wellbeing officers; renovation of the doctor’s office spaces and the development of a social media app.” Page 10, Lines 16 to 19 now read: “the recorded workshops were circulated to all 55 DiT however it is not known how many viewed them in

Apologies if I have misunderstood and workshop attendance was much higher.	their own time."
Reviewer 2	
Page 4, line 24 - spelling 'loosing' should be 'losing'	Thank you. We have corrected this error.
Page 10, line 41: Communication - can you give a free text example?	Thank you for asking us to expand the examples, we have done so. Page 12, Lines 37 to 54 now read: "Communication: The program offered alternative ways to share information and opened up communication vertically and horizontally. Investing in the revamping of the doctor's office space was experienced as a powerful gesture by participants. The program was described as having created a "space to talk" allowing trainee doctors to "hear each other". Another participant explained, "The workshop on giving feedback; asking for feedback and how to give feedback in a constructive, rather than critical way, I took that on. I will definitely remember that in the future. The workshop normalised open conversation". Others observed an increase in interactions with colleagues, More open communication facilitated supporting each other, "When I spoke about what I was going through, others then asked me for a coffee or a meal and shared their version of not being okay.""
Limitations: I feel the response rate and how this may include bias needs to be discussed. Did people who felt a positive outcome feel more likely to respond. If people are feeling disengaged would they want to fill out surveys on their wellbeing?	Thank you for asking for further clarification of the response rate and the impact of non-response bias. We have acknowledged this limitation and further explained the factors contributing. We have brought attention to the P2P and co-design approach to the development and delivery the program and strength of the mixed-methods evaluation in drawing out the programs impacts. Page 16, Lines 20 to 36 now read: "Participation in the workshop component of the program was only 30.9% (n=17), despite the workshops being delivered during dedicated teaching time. This highlights the demands being placed on trainee doctors over this time and reflects the practice of clinical responsibilities taking priority over educational opportunities. The P2P and co-designed structuring of the program as a 'toolkit' enabled the workshop content and initiatives to reach the non-attending DiT, affecting a rapid execution of changes and success of the program. We also self-imposed limitations on the collection of participant characteristics in order to preserve anonymity." Page 16, Lines 44 to 53 now read: "Given the collection of data was dependent on the voluntary completion of interviews and surveys our analysis is subject to non-response bias. Raising the possibility that those who responded were more motivated and healthier, and people with more burnout or depression did not respond. Our small numbers limited the ability to undertake inverse probability weighting or multiple imputation to address this. The mixed-methods design strengthened the findings of the evaluation, providing insight and breadth to inform future implementations."

VERSION 2 – REVIEW

REVIEWER	Rich, Antonia University College London Medical School, Research Department of Medical Education
REVIEW RETURNED	19-Aug-2022

GENERAL COMMENTS	Thank you very much for thoroughly addressing all my comments.