CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	The second victim: a contested term?
Authors	Tumelty, Mary-Elizabeth
Publication date	2018-12-18
Original Citation	Tumelty, M. E. (2018) 'The Second Victim: A Contested Term?', Journal of Patient Safety, December, doi: 10.1097/PTS.0000000000000558
Type of publication	Article (peer-reviewed)
Link to publisher's version	10.1097/PTS.0000000000000558
Rights	© 2021 Wolters Kluwer Health, Inc. All rights reserved. This is a non-final version of an article published in final form in Journal of Patient Safety: December 18, 2018, doi: 10.1097/PTS.0000000000000558
Download date	2026-11-11 06:19:51
Item downloaded from	https://hdl.handle.net/10468/12207

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

The Second Victim: A Contested Term

Mary-Elizabeth Tumelty

This is a pre-edited version of ME Tumelty, 'The Second Victim: A Contested Term' (2018) Journal of Patient Safety (Volume Published Ahead of Print) (DOI: 10.1097/PTS.0000000000000558)

Abstract

Objectives

The term 'second victim' was seminally coined by Wu, in recognition of the profound and long-lasting impact adverse events and medical errors may have on medical practitioners. Since the conception of this vocable over a decade ago, the term 'second victim' has been internationally accepted and is widely used in discussion of this important topic. Notwithstanding its widespread use, controversy surrounds the term 'second victim' in light of the traditional connotations with the word 'victim'. However, notable in their absence are the views of medical practitioners on the use of this term. This article addresses this gap through an exploration of perceptions on the terminology used to describe physicians who experience distress following an adverse event or medical error.

Methods

This research arose as part of a wider study on the dynamic of medical negligence litigation in Ireland. The study employed a qualitative approach, using semi-structured interviews as the data gathering instrument. The sample involved representatives of medical training bodies (2 individual interviews and one focus group of 4 individuals) and legal professionals (barristers) (12 individual interviews). Those interviewed from medical training bodies were physicians who have an active role in the College providing training and support to their members.

Results

A number of participants shared their views on the term 'second victim', and the findings of this study suggest that some physicians and legal professionals are uncomfortable with the term 'second victim' despite its widespread use in other jurisdictions. This is due to the traditional connotations that surround the term 'victim', and the perception that being labelled a 'victim' may undermine the harm suffered by the patient.

Conclusion

Whilst the impact of adverse events and medical error on the physician is undisputed, use of the term 'second victim' can be seen as insensitive to the patient, as well as dissipating the professional identity of the healthcare provider. 'Second victim' is an internationally-recognised term, as coined by Wu (2000). Finding an appropriate replacement is an important, but difficult task.

Introduction

Previous international research has recognized the profound impact an adverse event or medical error can have on a physician.[1] Although a patient who experiences harm as a result of medical error, omission, and/or an adverse event, is the first and most obvious victim, research has illustrated such events can also be traumatic for the healthcare provider involved, thus rendering them the 'second victim'. The concept of the healthcare professional as a 'second victim' was first introduced by Wu in 2000, where he explained:

> 'Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims'.[2]

It is well-accepted that following an adverse event or medical error, a physician may experience short-term emotional distress including feelings of guilt, anger, fear, embarrassment, and depression,[3] or may suffer from more severe and long-lasting conditions such as post-traumatic stress disorder (PTSD).[4]

Notwithstanding the fact that it is well-accepted that adverse events and/or medical error can have a significant impact on the healthcare professional involved, less consensus surrounds the term 'second victim'. The word 'victim' has a powerful meaning. This is because 'victim' is a potent word, laden with emotive and evaluative significance.[5] In a recent article, Wu et al. recognized issues with the term 'victim' in this context, as it may 'connote passivity or stigmatize involved clinicians', additionally, it may be perceived to deemphasize the experience of the patient and their family.[6]

The terminology used to describe the experience of the healthcare professional is not insignificant, and may have implications for patient safety. Where a healthcare professional is uncomfortable using such a term or being labeled a 'victim', they may be unlikely to seek help for the symptoms that they are experiencing such as sleeplessness, stress, and anxiety. Such symptoms have the potential to affect and/or impair a physicians' clinical decision-making in the aftermath of an adverse event, and so put other patients at risk.[7]

Interestingly, although the term has been widely accepted in the literature, there is no study which seeks the perspective of healthcare providers or the general population on the term 'second victim'.[8] In addressing this gap, this article explores the perspectives of medical professional training bodies and barristers, on the term 'second victim'.

Methods

Semi-structured Interviews

Research providing qualitative insights into perceptions on the term 'second victim' is non-existent,[9] and as such, this study aims to address this gap for the first time. Following approval from the institutional ethics review board,[10] qualitative methods (semi-structured interviews) were employed as part of a wider study on the dynamics of medical negligence litigation in Ireland. Interviews have been recognized as a fundamental method for collecting data as they enable rich insights into the phenomenon

under investigation to be captured, and are particularly useful when such knowledge does not exist elsewhere.[11]

There are many types of interview technique a researcher can choose from, including: structured, semi-structured or unstructured interviews.[12] The type of style the researcher should choose will generally depend on the level of depth needed, the degree of control required by the researcher, and the nature of the research question.[13] In the case of this research, a semi-structured interview format was employed, due to its flexible nature. As Wengraf explains:

> 'semi-structured interviews are designed to have a number of interview questions prepared in advanced but such prepared questions are designed to be sufficiently open that the subsequent questions cannot be planned in advance, but must be improvised in a careful and theorized way'.[14]

It is a particularly effective interviewing technique because it enables the researcher to gather the information required to satisfy the aims of the research while also allowing the participant to freely describe and clarify situations.[15] Thus, the semi-structured interview offers a degree of flexibility, wherein the participant can freely discuss their viewpoint, whilst contemporaneously providing the researcher sufficient control to ensure the research questions can be answered. [16]

Interview questions were guided by key concepts which emerged during the literature review, focusing on perspectives of the term 'second victim', for further detail please see table 1 attached. Open-ended questions were posed to facilitate the collection of rich, detailed data,[17] and a variety of medico-legal issues were covered including perspectives on the impact of litigation, and the views of participants on the term 'second victim'. Interviews were tape-recorded, and subsequently transcribed, and coded by the researcher.[18]

Sampling

The sample involved representatives of medical training bodies (2 individual interviews and one focus group of 4 individuals) and legal professionals (barristers) (12 individual interviews). Those interviewed from medical training bodies were physicians who have an active role in the College providing training and support to their members.

This study employed purposive sampling, an overview of which will now be provided.

Medical Professional Training Bodies

Although the focus of this article is on the term 'second victim', this study was more broadly focused on exploring the impact of medical negligence litigation on the medical practitioner. However, international research suggests that medical negligence litigation can have a destructive emotional impact on the medical practitioner.[19] This raised an ethical concern, as the primary responsibility of any researcher is the protection of their participants.[20] As Lewis asserts, researchers have a duty to protect participants from harm. This is because qualitative interviews have the potential to 're-evoke painful memories or emotional conflicts for participants both during the interview and afterward'.[21] As such, DiCicco-Bloom and Crabtree argue 'investigators must be prepared to provide psychological support if their interviews create undue stress or raise psychological complications'.[22] Due to the sensitive subject matter of this research, it was decided that representative groups who support medical practitioners through litigation would be more appropriate than individual participants i.e. individual medical practitioners. In addition, it was recognised that such groups have a wealth of knowledge and

experience, accordingly, their insights would be likely to answer the research question sufficiently.[23] All representatives from each of the medical training bodies had experience of medical negligence litigation in a professional and/or personal capacity.

Purposive sampling was employed for this section of the research. Purposive sampling involves identifying potential participants who match certain characteristics considered suitable for achieving the objectives of the research study.[24] Merriam has highlighted the importance of purposive sampling, and asserts:

> '…since qualitative inquiry seeks to understand the meaning of a phenomenon from the perspectives of the participants, it is important to select a sample from which most can be learned.'[25]

Thus, interviews were conducted with Irish Medical Professional Training Bodies (3), as these were identified as suitable participants to speak to the phenomenon under investigation. The three medical professional training bodies in Ireland are the Royal College of Surgeons, Ireland (RCSI), the Royal College of Physicians, Ireland (RCPI), and the Irish College of General Practitioners, Ireland (ICGP). Participants were contacted by e-mail with a description of the study. For those willing to participate, a face-to-face interview took place in a private location.

Although all other interviews adopted an individual, semi-structured format, at the request of the ICGP, a focus group interview was facilitated. The group comprised of four members, all of whom had professional experience in relation to the impact of medical negligence litigation, and two of whom also had personal experience of the phenomenon. The researcher acted as the moderator, whose role was to create a supportive environment.[26] This facilitated interaction between group members, wherein all participants could share their views, and allowed the moderator to interject probing questions when necessary.

The use of a focus group in the research was identified as a means of adding valuable insights by enabling the 'purposeful use of interaction in order to generate data'.[27] In addition, the utilisation of a focus group ensured methodological rigor.[28] By employing both a semi-structured interview format and a focus group, this research achieved method triangulation. Seale explains that method triangulation takes place when two or more methods are employed 'so that the biases of any one method might be cancelled out by those of others'.[29]

Confidentiality issues in relation to focus groups did not arise in the context of this research as participants waived their right to anonymity.[30] Whilst members of the focus group waived their right to anonymity, the researcher chose to only identify the professional body (ICGP), as naming individual participants in this context did not add to the explanatory power of the research findings.

Given the small number of medical training bodies in Ireland, anonymity could not be guaranteed to the Irish Medical Professional Training Bodies, however this was not a problem as participants were happy to be represented in the research and chose to waive their anonymity.

Legal Professionals (Barristers)

Barristers who specialise in medical negligence litigation were identified as suitable participants given their expertise and involvement in the phenomenon under study. Barristers for this research were sampled using random purposive sampling. Random purposive sampling is a form of purposive

sampling whereby the researcher generates selection utilising a random generator tool from a list of those who meet the criterion i.e. those that are deemed to be information rich and of interest to the study in question.[31] This sampling strategy is useful when there is no apparent reason to select one participant who meets the criteria over another.[32] The sampling framework in this research involved junior counsel and senior counsel who self-identified as specialists in medical negligence litigation on the Bar Council website.[33] From this sample (34), practitioners were chosen at random using a generator tool, to be included in the study, as this represented one-third of the population under study. Qualifying participants were sent an introductory e-mail inviting them to participate and following a response, an interview was scheduled, the location of which was mutually agreed upon. A total of twelve barristers participated in this research

Barristers were guaranteed anonymity, and therefore, no distinction is made between male and female participants, junior or senior counsel, or plaintiff or defendant counsel, given the small nature of the jurisdiction and the potential for such details to pose a risk to anonymity. Before each interview, the consent form was reviewed and signed.

Results

The findings of this research indicate resistance to the use of the term 'second victim' when describing the symptoms physicians may face following an adverse event or medical error. It is important to note that although not all participants spoke to the term 'second victim', all participants recognized the impact that medical error and/or litigation can have on clinicians.

Both medical professional training bodies and barristers demonstrated a reluctance to use the term, despite being aware of the profound and long-lasting impact medical error can have on a physician. All members of the ICGP focus group (4) spoke of their dissatisfaction with the term 'second victim', similarly, the two remaining medical professional bodies spoke of the negative connotations with the term 'victim'. Whilst not all barristers spoke directly to the term, of those who did (4), there was consensus that the term is contested, the reasons for which we will now discuss.

Discussion

Although the majority of barristers and all medical professional bodies agreed and spoke to the profound emotional impact an adverse event and litigation can have on the physician, several participants contested the term 'second victim'.

> 'I don't like the term "victim"… it's not an appropriate term, we need to come up with a better term.' (Group Member 4, ICGP)

> 'We have actually discussed looking for another term… [but] if that's the word we have to use well then that's [fine], I think there's probably another word... but there's no internationally-recognised term, other than the "second victim".' (Group Member 1, ICGP)

> 'The only thing I would feel about the term "second victim" is that it would be perceived as "oh those doctors are just looking after themselves, and thinking of themselves". I'm not that mad about it...' (Group Member 2, ICGP)

Although these comments indicate that medical professionals want to create an awareness of the impact of adverse events and medical errors, they highlight the current dissatisfaction with the use of the term

"victim". Participants were particularly cognisant of the views of the patient and aware that use of the term 'victim' may appear to devalue the impact of the adverse event or medical error on the patient.[34] These views are in line with a body of research in the broader victimology discourse, where scholars such as Leisenring have suggested:

> '…the assigning or claiming of a victim identity – and consequently, the receipt of sympathy and assistance – is strongly tied both to existing public constructions of victims and to how individuals derive meaning from these constructions'.[35]

Similarly, Lamb notes that the advance of victim ideology has created the notion that "everyone's a victim", obscuring the pain and anguish that "real" victims suffer.[36] Accordingly, it is somewhat unsurprising, that physicians, who are in a 'caring profession', are uncomfortable with the use of a term which may lessen or undermine the experience of the patient who is likely to have suffered physical and/or psychological harm as a result of the adverse event or medical error. Given the often serious and life-long consequences a medical error may have on a patient, the use of such a term may 'add insult to injury'. Interestingly, the findings of this research suggest that the public perception of the physician was important to the medical practitioner, and employing the term 'second victim' may result in a perception that "… those doctors are just looking after themselves, and thinking of themselves" (Group Member 2, ICGP).

Barristers also expressed uncertainty over the term 'second victim', despite recognizing the profound and long-lasting impact that adverse events, medical error, and/or litigation can have on a physician. One barrister rejected the concept of the medical practitioner as a 'victim', noting:

> 'I think the difficulty is not so much the doctor being the "victim", I think that's for the doctor to decide...' (Barrister 4)

In noting the difficulties with the term 'second victim', Barrister 3, upon reflecting on their professional experience with healthcare providers, also referenced the significant difficulties physicians often encounter following medical error and/or during litigation. Accordingly, they argue that although the use of the term 'second victim' has been contested, in their experience, medical error and/or litigation has a significant impact on the physician and as such should be recognized:

> 'People may disagree as to whether there is any such thing as a second victim at all, compared to an individual who has suffered physical and psychological harm, but I can only give you an honest assessment of my work, and the clients I have dealt with.' (Barrister 3)

As such, it is clear that there is a consensus as to the impact adverse events and/or medical error can have on the medical profession, however, the results of this research suggest that this notwithstanding, there is a clear reluctance to use the term 'victim' in this context.

Professional Identity and the Doctor as a "Victim"

Interestingly, although all medical professionals focused on the perception of the term 'victim' and its likelihood to undermine the experience and suffering of the patient, the issue of the impact of the term 'victim' on the professional identity of the doctor also arose, which will now be explored.

International research indicates that many physicians have a strong sense of professional identity.[37] Thoits notes that 'positional roles provide the individual with a sense of who they are and how they ought to behave'.[38] Thus, frequently a role identity provides an individual with a meaning for self.[39] In the context of the medical profession, Cruess et al. assert that a doctor's identity is a 'representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical

profession are internalized, resulting in an individual thinking, acting and feeling like a physician'.[40] Hilfiker has observed that 'the medical profession seems to have no place for its mistakes'.[41] Participants spoke to this, and concurred:

> 'We're by nature, perfectionists and very conscientious, and for a lot of us that's our downfall… the identity of the doctor is very much rooted within themselves. As part of the process of becoming a professional, we take on the role of doctor in almost every cell in our body, even when we go on holidays we're still doctor, when we register in the hotel or check-in, we become doctors 24 hours a day and if something happens… that goes to our very soul and it's very traumatic.' (Group Member 1, ICGP)

> 'For doctors, generally speaking, making mistakes is very, very difficult… they find [it] very difficult to cope... The ones that remain with them are the traumatic ones, where they might have made a mistake.' (RCPI)

Situating the construction of "second victim" within the broader victim discourses is necessary to fully understand cultural meanings surrounding the term "victim". For instance, Best,[42] Lamb,[43] and Holstein and Miller,[44] note that a common representation of a victim is someone who is 'passive' and 'powerless'. Given this strong sense of professional identity the rejection of the term "victim" is conceivable.

Due to the traditional association of the term 'victim' with someone who is perceived as 'helpless' or 'worthy of sympathy', it is understandable that physicians are uncomfortable with the term, particularly in the context of medical error wherein a patient is likely to have suffered physical harm.

Limitations and Further Research

This study has addressed an important and previously unexplored subject. The most obvious limitation of this research is the small number of participants in the study and the absence of the patients' perspective on this topic.

Although medical professional training bodies were sampled to gain the broadest practicable range of experience, given their role and interaction with physicians, further research should be designed to include larger samples and should include the perspectives of individual physicians to gain more detailed insights.

Barristers were selected in this study given their extensive interaction with both patient-plaintiffs and medical practitioners. However, as noted above, the viewpoints of patients on this topic is an important avenue worthy of exploration. Therefore, future research in this area should seek to include the patient perspective.

Conclusion

The findings of this research suggest that there is dissatisfaction, particularly amongst healthcare providers in relation to the term 'second victim'. Be that as it may, the term 'second victim' has brought widespread international awareness to the impact that adverse events and/or medical error can have on physicians. As Wu et al. explain:

> '… It may be most appropriate to label this important phenomenon in a way that local leaders are most comfortable with-in a way that promotes its recognition and adoption of solutions…

> For policy makers and health care managers, the term second victim may have value because it is memorable and connotes urgency.'[45]

Although the term has the ability of the term to bring awareness to the impact of medical error on medical practitioners, the findings of this research suggest that the term 'second victim' is contested and is in need of re-visitation. Until we find an appropriate, internationally recognized term, it is likely that the use of the term 'second victim' will continue. It is suggested that such a term should come from those involved: patients and physicians, who are best placed to assign meaning to this phenomenon.

[1] Ullström S, Sachs MA, Hansson J, et al. Suffering in silence: a qualitative study of second victims of adverse events. *BMJ Qual Saf.* 2014;23(4):325-31
Charles SC. Coping with a medical malpractice suit. *Western Journal of Medicine* 2001;174(1):55.
[2] Wu AW. Medical error: the second victim: the doctor who makes the mistake needs help too. *BMJ: British Medical Journal* 2000;320(7237):726.
[3] Seys D, Wu AW, Gerven EV, et al. Health care professionals as second victims after adverse events: a systematic review. *Evaluation & the health professions* 2013;36(2):135.
[4] Scott SD, Hirschinger LE, Cox KR. Sharing the load. Rescuing the healer after trauma. *Registered Nurse Journal* 2008;71(12):38.
[5] Van Dijk J. Free the victim: A critique of the western conception of victimhood. *International Review of Victimology* 2009;16(1):1.
[6] Wu AW, Shapiro J, Harrison R, et al. The impact of adverse events on clinicians: what's in a name? *Journal of Patient Safety* 2017.
[7] Quillivan RR, Burlison JD, et al. Patient Safety Culture and the Second Victim Phenomenon Jt Comm J Qual Patient Saf. 2016; 42(8): 377.
[8] Wu AW, Shapiro J, Harrison R, et al. The impact of adverse events on clinicians: what's in a name? *Journal of Patient Safety* 2017.
[9] Wu AW, Shapiro J, Harrison R, et al. The impact of adverse events on clinicians: what's in a name? *Journal of Patient Safety* 2017.
[10] Faculty of Arts, Humanities, and Social Sciences, University of Limerick.
[11] Creswell JW, Creswell JD. Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications, 2017.
[12] Creswell JW. Qualitative Inquiry and Research Design: Choosing among five approaches. Sage publications, 3rd edn, 2013. Qu S, Dumay J. The qualitative research interview. *Qualitative Research in Accounting and Management* 2011; 8(3): 238.
[13] Creswell JW. Qualitative Inquiry and Research Design: Choosing among five approaches. Sage publications, 3rd edn, 2013.
[14] Tom Wengraf T. Qualitative Research Interviewing: Biographic narrative and semi-structured methods. Sage publications, 2001: 5.
[15] Walker W. Hermeneutic Inquiry: Insights into the process of interviewing. *Nurse Researcher* 2011;18(2): 19.
[16] Maxwell JA. Designing a qualitative study. *The SAGE Handbook of Applied Social Research Methods* 2008;2: 214. Rubin HJ, Rubin IS. Qualitative Interviewing: The Art of Hearing Data. Sage publications, 2nd edn, 2011.
[17] Gill P, Stewart K, et al. Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal* 2008; 204(6): 291.
[18] DiCicco-Bloom B, Crabtree BF. The qualitative research interview. *Medical education* 2006;40(4):314.
[19] Strasburger LH, The litigant-patient: Mental health consequences of civil litigation. *Journal of the American Academy of Psychiatry and the Law* 1999; 27(2): 203. Charles SC, Coping with a medical malpractice suit. *Western Journal of Medicine* 2001; 174(1): 55.
[20] Fane Lewis F, 'Design Issues' in Ritchie J et al. (eds) Qualitative research practice: A guide for social science students and researchers. Sage publications, 2013.
[21] Hadjistavropoulos T, Smythe WE. Elements of risk in qualitative research. *Ethics & Behavior* 2001; 11(2): 163: 167.
[22] DiCicco-Bloom B, Crabtree B. The qualitative research interview. *Medical Education* 2006; 40(4): 314: 319.
[23] An unanticipated finding of this research was that at present, support groups for medical practitioners facing negligence actions are virtually non-existent in Ireland. However, in recognition of the need for supports for medical practitioners who are subject to medical negligence litigation, the leading medical training bodies in Ireland: the Irish College of General Practitioners (ICGP), the Royal College of Surgeons (RCSI), and the Royal College of Physicians (RCPI), have over the past number of years implemented support services as part of their wider frameworks. The ICGP established a 'health in practice programme' in 2000, which in addition to other supports not relevant to the present discussion, provides support to doctors who face medical negligence

litigation. RCPI offer support to physicians through various wellbeing initiatives such as courses, workshops, and counselling services. RCSI also offer support to surgeons who face claims of medical negligence. Under the 'Surgeons in Practice' initiative overseen by the Dean of Professional Development and Practice, a number of programmes are available to surgeons who face professional or personal difficulties. For further information please see, http://www.icgp.ie/go/in_the_practice/doctors_health; http://www.rcpi.ie/physician-wellbeing/; http://www.rcsi.ie/about-surgeons-in-practice

[24] Merriam S. Qualitative Research in Practice: Examples for discussion and analysis. Jossey-Bass Inc Pub, 2002: 12.

[25] Merriam S. Qualitative Research in Practice: Examples for discussion and analysis. Jossey-Bass Inc Pub, 2002: 12.

[26] Basch CE. Focus group interview: An underutilized research technique for improving theory and practice in health education. *Health Education & Behavior* 1987; 14(4): 411, 415.

[27] McLafferty I. Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing* 2004; 48(2): 187.

[28] Bryman A. Integrating quantitative and qualitative research: how is it done? *Qualitative Research* 2006; 6(1): 97.

[29] Seale C. Quality in qualitative research. *Qualitative Inquiry* 1999; 5(4): 465, 473.

[30] Kitzinger J. Qualitative research: Introducing focus groups. *British Medical Journal* 1995; 311(7000): 299, 300, wherein it is noted that 'the presence of other research participants… compromises the confidentiality of the research session'.

[31] Tongco MD. Purposive sampling as a tool for informant selection. *Journal of Plants, People and Applied Research* 2007; 5: 147.

[32] Patton MQ. Qualitative Research and Evaluation Methods. Sage publications, 3rd edn, 2002: 240.

[33] See generally, www.lawlibrary.ie

[34] Wu AW, Shapiro J, Harrison R, et al. The impact of adverse events on clinicians: what's in a name? *Journal of Patient Safety* 2017.

[35] Leisenring A. Confronting "victim" discourses: The identity of battered women. *Symbolic Interaction* 2006; 29(3): 307, 309.

[36] Lamb S. The Trouble with Blame: Victim, Perpetrators, and Responsibility. Harvard University Press ,1996: 20.

[37] See for example, Allsop J, Mulcahy L. Maintaining professional identity: doctors' responses to complaints. *Sociology of health & illness* 1998;20(6):802.
Cruess RL, Cruess SR, Boudreau JD, et al. Reframing medical education to support professional identity formation. *Academic Medicine* 2014; 89(11):1446.
Sullivan WM. Medicine under threat: professionalism and professional identity. *Canadian Medical Association Journal* 2000;162(5):673.

[38] Thoits PA. On merging identity theory and stress research. *American Sociological Association* 1991; 54(2): 105.

[39] Hogg MA, Terry DJ, et al. A tale of two theories: A critical comparison of identity theory with social identity theory *Social Psychology Quarterly* 1995; 58(4): 255.

[40] Cruess RL, Cruess SR, et al. Reframing medical education to support professional identity formation *Academic Medicine* 2014; 89(11): 1446, 1447.

[41] Hilfiker D. Facing our mistakes. *New England Journal of Medicine* 1984; 310: 118, 121.

[42] Best J. Victimization and the Victim Industry. *Society* 1997; 34(4): 9.

[43] Lamb S. The Trouble with Blame: Victim, Perpetrators, and Responsibility. Harvard University Press ,1996: 20.

[44] Holstein JA, Miller G. Rethinking Victimization: An Interactional Approach to Victimology *Symbolic Interaction* 1990; 13(1): 103.

[45] Wu AW, Shapiro J, Harrison R, et al. The impact of adverse events on clinicians: what's in a name? *Journal of Patient Safety* 2017.

TABLE 1. Semistructured Interview Guide

Interview Guide ***Main Focus***	***Probe For***
Do you think medical error or adverse events impact on healthcare professionals? Are you familiar with the term “second victim”? What is your view on the term? How do you think the term is perceived by others e.g. patients, the general public?	Specific examples and situations of individual impact. Reasons for a particular viewpoint. Examples.