What is the lived Experience for Doctors when they are Involved in a Serious Incident?

A Descriptive Phenomenological Analysis.

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Abstract

Within the National Health Service (NHS), when a serious incident (SI) occurs that harms a patient, understandably, the patient and their families are the primary focus. However, Wu (2000) recognised that the medical doctors involved in the SI, whom he termed “second victims”, can also experience psychological distress. This research aimed to explore the lived experiences of second victims, to better understand the second victim phenomenon, as given. The rationale for this research is highlighted through a critical review of the relevant existing literature, which revealed this to be predominately empirically driven, or otherwise interpreted or thematicised.

Seven medical doctors were interviewed utilizing a semi-structured interview questionnaire. A Descriptive Phenomenological Analysis was undertaken to conduct an in-depth analysis of the data. The data were sectioned into meaning units and further scrutinised, to identify any psychologically sensitive elements. These were then transformed into nine constituents, which were synthesised to construct the general psychological second victim phenomenon.

The findings indicate that doctors experience profound psychological distress at the moment they realise a SI has occurred, from which they never fully recover, concealing and suppressing the emotions the SI has provoked to their own psychological detriment. They feel changed, subsequently altering their work practices, becoming hypervigilant and avoidant. Their self-identities are damaged along with their sense of expertise as doctors, with symptoms indicative of post-traumatic stress disorder manifesting. Nonetheless, they do not consider seeking psychological support, as it is not a part of the clinical culture they have been socialised into since medical school.

These findings provide a unique insight into the lived experience of doctors who have been involved in SIs. The clinical implications are discussed in the context of the current literature, leading to recommendations for training and psychological support for clinicians as crucial interventions to help alleviate the psychological distress of second victims.

Abbreviations

BBC: British Broadcasting Corporation

BMA: British Medical Association

BMJ: British Medical Journal

BPS: British Psychological Society

CBT: Cognitive Behavioural Therapy

CISD: Critical Incident Stress Debriefing

CoP: Counselling Psychologist

DPA: Descriptive Phenomenological Analysis

DSM-V: Diagnostic and Statistical Manual of Mental Disorders

EMDR: Eye Movement Desensitisation and Reprocessing

GMC: General Medical Council

IPA: Interpretive Phenomenological Analysis

NA: Narrative Analysis

NaPSIR: National Patient Safety Incident Reports

NICE: National Institute for Clinical Excellence

NE: Never Event

NHS: National Health Service

NPSA: National Patient Safety Agency

PTSD: Post Traumatic Stress Disorder

RISE: Resilience in Stressful Events

SI: Serious Incident

UK: United Kingdom

UMHC: University of Missouri Health Care

USA: United States of America

List of Tables

Table of Contents

CHAPTER 1

INTRODUCTION

> *"The sorrow of mistakes has been expressed as the too-lateness of human understanding as it lies along the continuum of time, and as a wish that it might have been different both then and now"* (Paget 1988, p. 149)

1.1 Overview

This chapter commences with a brief account of how I came to be driven to research the experiences of doctors who have been involved in serious incidents (SIs). This is followed by a history of patient safety in the National Health Service (NHS). Then, I outline the aims of my research and provide an explanation of my epistemological and ontological positioning, in order to clarify my methodological choices. I provide a brief synopsis of the background of the second victim phenomenon and state how I believe the findings of this study will provide insights for medical clinicians, counselling psychologists and the wider psychology community. I conclude with information about the discontent from some patient groups about the term second victim and explain why I have continued to use it.

1.2 The journey towards this thesis: A personal context

After many years in clinical research, I changed career to become a patient safety manager working with three gifted nurses. Under their tutelage, I managed several SIs and observed them supporting the clinical staff involved with compassionate efficiency. I then moved to another hospital where there was a very different approach. I witnessed the clinicians who had been involved in SIs stoically hide any emotional response from the patient safety team, whose focus was to investigate the error. I learned of the extent of the doctors' pain during a training session I delivered to them about the concept of the second victim. Unable to bring about change, I left the NHS to free myself from the constraints of my role, so that I could try to do something that might alleviate the impact of their experiences of being involved in a SI and encourage an ethos of support for these wounded healers.

I knew this would be my research topic three years before I started this doctorate. However, it was only in my second year that I stopped thinking empirically about my research and fully appreciated that I had the opportunity to look at the second victim field of research with a different, more humanistic lens. The more I identified with counselling psychology, the more I realised that the most important thing I could do for second victims, was to listen to them - hushing my own voice, putting aside those methodologies that might theorise or interpret their experiences, allowing my participants to speak for themselves and remaining true to their accounts throughout the research process.

1.3 The History of Patient Safety in the National Health Service (NHS)

The NHS was launched on July 5th July 1948 by Aneurin Bevan, to provide a unified medical service to the British public. It had at its heart three core principles: "That it meets the needs of everyone, that it be free at the point of delivery, and that it be based on clinical need, not ability to pay" (Pater, 1981). In the 1960s this idyllic imagery of the NHS was shaken by a book written by Jungian psychotherapist Barbara Robb, entitled 'Sans Everything: A Case to Answer' (1967), which highlighted the ill-treatment of older people in NHS psychiatric hospitals. The ensuing scandal prompted the government to draw up new policies of change and led to the creation of the Hospital Advisory Service, which was tasked with inspecting hospitals, identifying problems and making recommendations. Throughout the 1970s the NHS underwent changes in relation to patient safety. For instance, the Merrison Committee's report (1975) highlighted that a third of practicing doctors in the UK were unqualified and there was no means of knowing who they were. They proposed a plan to merge the nineteen bodies that regulated medicine into one, the General Medical Council (GMC). This led to the requirements for all doctors to be registered with the GMC and for medical education to be standardised across the UK.

A play written by Peter Ransley (1980) and broadcast by the BBC called 'Minor Complications' told the story of medical injuries in the NHS. It was the first time that medical errors had been addressed so publicly. It received such an overwhelming response from the viewers, offering their experiences of medical errors, that the author set up a charity, 'Action for the Victims of Medical Accidents'. which continues to influence patient safety reforms in the NHS to this day. The rest of the 1980s saw the focus upon patients' wellbeing increase and by the end of the decade, clinical audit was formalised by the publication of the white paper "Working for Patients" (Roberts, 1989).

In the 1990s the NHS was rocked by several events, including the case of Beverley Allitt, the nurse who murdered and harmed several children, the Bristol heart scandal, where the deaths of 23 paediatric cardiac patients were found to have been caused by clinical arrogance and negligence, and the murder of approximately 250 patients by Dr Harold Shipman. These cases highlighted "unacceptable variations in clinical practices and outcomes" (Braine, 2006, p. 56), leading to a political and public outcry, with, for example, the British Medical Journal (BMJ) publishing an editorial entitled “All changed, utterly changed” (Smith,1998), demanding that rapid, effective action be taken to prevent such occurrences from happening again - otherwise British doctors would have to be micromanaged.

In response to these incidents, in 1997, the government introduced clinical governance into the NHS, through which Hospital Trust Boards would be held responsible for the quality of clinical care their patients received. Clinical governance is, in short, “doing anything and everything to maximise quality” (Braine, 2006, p57), and resulted in clinical risk coming into sharp focus. The publication in the USA of the white paper “To Err is Human: Building a Safer Health System” (Kohn, 1999), a critical report about patient safety in American hospitals, led to a further flurry of improvements in the UK, including the creation of the National Institute of Clinical Excellence (NICE). NICE draws up guidance for practice based upon clinical experts’ scrutiny of the most robust evidence gathered from the world literature for any given disorder..

The Department of Health published its own damning report entitled “An Organisation with a Memory” (Donaldson, 2002) that gave the sobering statistic that 850,000 (approximately 1 in 10) in-patients encounter an adverse event. This prompted the establishment of the National Patient Safety Agency (NPSA) and the Commission for Health Improvement, amongst other regulatory bodies. These organisations were the bedrock for modern patient safety in the NHS.

The NPSA was disbanded when NHS England was established in 2012, leaving as its legacy the Serious Incident Framework, which remains in use today and provides the means by which incidents are reported and investigated. It also sets out the classifications of incidents, from low or no harm to SIs, including never events, which are incidents that should never happen under any circumstances because they are so dangerous while being relatively easily preventable. Patient safety is a constantly evolving entity and nowadays is at the forefront of most NHS employees' minds.

The NHS is probably safer than it ever has been. When a SI occurs, a comprehensive safeguarding process is triggered, which ensures that everything is done to help the patient, their family and carers. The Healthcare Safety Investigation Branch operates in every NHS trust across England. They carry out independent, impartial investigations, based on the scale of risk. If necessary, a national alert can be issued in minutes, to inform every NHS establishment in the country of a newly discovered risk. Learning from incident programmes are drawn up and disseminated across the NHS. Those staff involved in a SI will write statements and attend incident meetings and will join patient safety staff to undertake a root cause analysis to establish how the SI happened. However, one rarely taken action is to check whether the clinicians involved in SIs are psychologically impacted. This is despite extensive evidence suggesting that clinicians who are involved in SIs, especially doctors, who are personally responsible for their patients, suffer psychological distress (Denham 2007; Dekker, 2013; Waterman Garbutt, Hazel et al. 2007) and even post traumatic stress disorder (PTSD) (e.g., Dekker, 2012; Harrison, Lawton et al. 2015; Wu 2000).

1.4 Doctors, SIs and Psychological Distress

It has been known for over 20 years that doctors can experience significant psychological distress symptoms after being involved in a SI,. Albert Wu (2000) coined the phrase 'second victim' in an article which explicitly detailed what can become of a doctor who makes a clinical error. This was evidenced by several empirical research studies, which posited that doctors' involvement in SIs is causal in their manifestations of psychological distress symptoms (e.g., Aaraas, et al., 2004; Aasland & Førde, 2005; Lander, et al., 2006; Schwappach & Boluarte, 2009; White, et al., 2008). NICE (2018) has very clear treatment guidelines for providing evidence-based psychological support for these psychological manifestations, yet currently doctors who have been involved in SIs are rarely offered this type of support. Perhaps, if the medical profession understood the second victim phenomenon better and what it means to doctors to be involved in a SI, they might be more likely to follow the NICE guidelines.

1.5 Research Aims

There has been much research and discussion into the psychological symptoms that doctors involved in SIs can manifest. Amongst this, there are numerous references to the second victim phenomenon, but the nature of this phenomenon has never been truly clarified (Tartaglia, & Matos, 2020). Therefore, the aim of this study was to develop a psychologically sensitive phenomenological structure of the second victim phenomenon, through the exploration of the lived experiences of doctors who had been involved in a SI, using Giorgi's (2017) descriptive phenomenological analysis (DPA) method,. The objective was to illuminate the nature of the phenomenon by identifying any manifestations of psychological significance that emerge from within the phenomenon, in order to better understand the phenomenon and to strengthen the argument for providing psychological support as recommended by NICE (2018).

1.6 Epistemological and Ontological Positioning

Prior to my role in patient safety, I worked as a research governance manager for a large, well known teaching hospital in London. At that time, my mind was empirically led, I monitored the ebb and flow of statistics and processes, and epistemology and ontology were concepts beyond my understanding. After leaving the NHS and joining this course, that changed dramatically. I arrived at my positioning with something of an inner struggle. No matter how hard I tried, I could not answer my own research question empirically; I realised that there were no parametric models that could adequately describe the experiences of doctors who had been involved in SIs.

I looked to the qualitative inquiry literature for a solution and I found the DPA method (Giorgi, 2017). I identified my positioning within this discipline. I believe that there is a reality beyond human consciousness but that our life experiences influence the curvature of the lens through which we peer at it; meaning cannot be imposed on individuals (Budd, 2012). Therefore, my ontological positioning was as a critical realist; I believe that SIs are a medical reality but that each individual experiences their error from within the boundaries of their own perceptions. I then decided that, if that is the case, it would be interesting to enquire of individuals what their SI experiences were, to see if there were any areas where their meaning making converged. Thus, my epistemology positioning is phenomenological. I chose Giorgi's (2017) DPA not only because it was congruent with my own positioning, but also, as doctors have a close relationship with scientific processes, they would understand Giorgi's (2017) approach. Having worked with doctors for years, I knew they would not be particularly interested in my opinions, but they would be very interested in what other doctors had to say about being involved in SIs.

1.7 Relevance to Counselling Psychology, the Wider Psychology Community and the Medical Profession

DPA was used because it is methodical and enables a psychological perspective to be adopted. This could be clinically pertinent for counselling psychologists and others in the wider psychology, counselling and medical communities, many of whom provide psychological support for doctors in various clinical environments. It could be educationally relevant to help current and future doctors to develop a transparent and open attitude to the second victim phenomenon, possibly facilitating discussions about how to seek help. Furthermore, if patient safety managers understood the impact that SIs might have on doctors better, they could potentially safeguard the doctors by signposting them towards psychological support. Finally, if policy developers in organisations such as NHS England were better informed about the second victim phenomenon, they could advocate for the recognition and support of doctors who are psychologically distressed by their experiences of being involved in a SI.

1.8 Terminology: Second Victim

Before proceeding with the research, I took into consideration that a small number of patient advocacy groups and academics, mainly in America are asking for the term second victim to be abandoned (Clarkson, Haskell et al., 2019). The authors suggested that organisations who use the term “subtly promote the belief that patient harm is random, caused by bad luck and simply not preventable” (p. 2). This was followed by a surge of ‘rapid responses’ from clinicians arguing that, whilst the term was an anathema to some, its use could be strongly defended because they believed it serves to prevent an adversarial approach towards doctors who have made an error and highlights their experience of psychological distress. Some of the responders suggested that the motives of Wu (2000) were not to evade responsibility but to serve the purpose of highlighting the difference between error and negligence (e.g., Gomez-Duran, et al., 2019; Kavanagh, 2019; McDonald, 2019). The furore continues but for me the assertions of those who use the term are persuasive and therefore the second victim terminology is used throughout this thesis.

1.9 Structure of Thesis

This thesis provides the journey of my research into the experiences of doctors who have been involved in a SI, in order to disclose the nature of the second victim phenomenon, and is structured as follows:. Chapter one is this introduction. Chapter two is a critical review of the existing literature into the second victim phenomenon and also provides the context and relevance of my research into doctors' experiences of being involved in a SI. In chapter three, I discuss each of the five steps of the descriptive phenomenological method in psychology that I used, following Giorgi (2017). I present the rationale for this choice of method and I outline my epistemological and ontological position and ethical concerns. Chapter four consists of the analysis of the constituents that were transformed from the data, supported by examples from the participants' transcripts, and the general phenomenological psychological structure of the second victim phenomenon. Chapter five contains my discussion of the analysis relevant to the existing literature, the strengths and limitations of the study, the significance of this research to counselling psychologists and the wider psychological and medical community and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Overview

According to Patel, et al. (2011), “the notion that human error should not be tolerated is prevalent in both the public and personal perception of the performance of clinicians” (p. 413). 62,500 SIs (incidents where patients come to harm or die because of clinical errors), were reported by NHS organisations to NHS Improvement between April 2019 and March 2020, so this perception is clearly unrealistic. It is recognised that doctors closely involved in a SI may manifest psychological distress and the term “second victim” was introduced by Albert Wu (2000), as outlined below, to describe the affected individuals.

This chapter critically reviews the literature related to the second victim phenomenon (for search strategy, see appendix B p 203). I discuss how, within the tradition of the medical model, clinicians strove to diagnose and find solutions to the second victim phenomenon, finding that a significant number of those involved in SIs report symptoms suggestive of post-traumatic stress disorder (PTSD). I explore subsequent clinical researchers’ rationale for extending the definition of the second victim to include all healthcare workers, and the impact that this had upon those who fell within the original criteria of the second victim. I present my rationale for proposing my current research, utilising Giorgi’s (2017) descriptive phenomenology method in psychology approach, to conduct an in-depth exploration of doctors’ experience of being involved in a SI, in order to better understand the second victim phenomenon. This chapter also explores the relevance of the topic to counselling psychology and ends with the research question.

2.2 Introduction

2.2.1 History and Background of Serious Incidents

Between April 2019 to March 2020, 1,609,520 incidents were recorded in England (National Patient Safety Incident Reports for England, [NaPSIR], 2020). This statistic is less alarming than it first seems given that the NHS deals with one million people every 36 hours (NHS Confederation, 2017) and that 95% of the reported incidents caused either little or no harm to patients (NaPSIR, 2018). The remaining 5% of incidents are classified as SIs. According to the NHS's SI Framework, the definition of a SI includes the: "…death of a patient who was not expected to die or where someone requires ongoing/long term treatment due to unforeseen and unexpected consequences of health intervention" (NHS England, 2015, p. 14). That is, a SI is where a patient comes to harm or dies because of a clinical error.

In the 1980s, a small number of doctors published short articles about their medical errors (e.g., Carmichael, 1985; Levison, Dunn et al., 1989), which according to Blumenthal (1994) happened "with rare exception" (p. 1867) at that time. One of the first people to publish a detailed account about his involvement in a SI was Dr David Hilfiker (1984). His honest narrative of how his medical intervention caused an unintended abortion provided insight into his experiences and the emotions he grappled with. Whilst writing with deep empathy toward the patient, he pondered, "mistakes are an inevitable part of everyone's life…but mistakes seem different for doctors…Few other mistakes are more costly" (p. 4). he continued: "my guilt and anger grew…I never shared with them [the patient and her husband] my own agony…I decided it was my responsibility to deal with my guilt alone" (p. 5).

These accounts were written by clinicians for their peers and were published in medical journals, which were not easily accessible to the public or even the wider healthcare community. Hilfiker (2013) later wrote that although his peers provided kind feedback to his article, it took ten years before another doctor wrote as candidly about their mistakes.

Perhaps the most profound research undertaken at that time into medical mistakes was conducted not by a clinician but by a sociologist who ironically, sadly lost her own life to a medical error less than a year after her work was published. Marianne Paget (1988) conducted in-depth interviews with forty physicians, which she audio-recorded. She did not formally set out her methodology but referred to her analysis as an existential interpretation of her data: "It is I who create the phenomenology of the mistakes of physicians." (p. 19). Paget (1988) did this by interpreting the discourse her participants used when discussing their errors with her. She stated that, "Medicine is an error-ridden activity" (p. 58). Paget (1988) posited that when realising that irreparable harm had happened, "the [clinician's] mind remembers, the mind turns back…regret resonates with other feelings of the spectrum of sorrow, with other losses. Sadness swells, pressing for release" (p. 86). Clinical error is, Paget (1988) says, "the complex sorrow" of medicine, in that "physicians experience the too-lateness for their patient" (p. 123).

Others had also started to explore the impact of medical errors upon clinicians' thoughts, feelings and coping mechanisms. Both Christensen, Levinson & Dunn (1992) and Newman (1996), carried out thematic analyses of their interview data from senior doctors. They found emotional distress and discomfort that had stayed with the clinicians throughout their careers. They both also identified evidence that, because of a sense of enduring shame, their participants found it difficult to talk about their errors. As Lazare (1987) said, “it is shameful and humiliating to admit that one has been shamed and humiliated” (p. 1658).

However, accounts of the clinicians’ experiences of errors were overshadowed in America in the 1990s by a national exposé of a large number of SIs that had taken place over a short period, after the death of a young reporter from the Boston Globe (Kohn,et al., 1999). It was an uncomfortable awakening for the American public, who, until that point, upheld “cherished myths” about the infallibility of the medical profession (Blumenthal, 1994, p. 1868). Understandably, research then focused on how to prevent medical errors as opposed to the experiences of the physicians involved (e.g., Cook & Woods, 1996; Dominguez, et al., 1998). The investigators turned to “human factors" research (Vincent & Bark, 1995), which is the study of how humans conduct themselves within complex organisational systems and organisational accident models (Reason, 1995). Generally, the focus of the research was upon the error events rather than the individuals and collective analyses were made of the actions of the staff and their working environment, leading up to the error. The researchers were clinicians and the research was conducted within an empirical frame. Thus, the first large studies into SIs were investigations into a hybrid of human behaviour and large systematic processes.

2.3 The Second Victim as Originally Defined

Following the publications about medical errors in the media, the American Institute of Medicine issued a white paper; “To Err is Human” (Kohn, et al., 1999), that reported that more people die from preventable clinical errors than from road traffic accidents, breast cancer or AIDs. They stated that this, “was not acceptable” from a system that pledges, “First, do no harm” (Kohn, et al. 1999, p. 2). In response to this white paper, Professor Albert Wu (2000), in what proved to be the seminal article on the topic, brought attention back to the doctors' experiences of making errors. Whilst emphasising that the patients and their family or carers are the primary concern when an incident occurs, he suggested that the doctors involved are also "wounded by the same errors" and, as such, are "second victims" (Wu, 2000, p. 726). He described a deficiency in organisational mechanisms in providing emotional support for clinicians involved in clinical incidents and painted a bleak picture of his observations of colleagues who had, "lost their nerve, burned out and sought solace in alcohol and drugs" (Wu, 2000, p. 727). He added that he believed that it is often the most sensitive doctors who are most injured by their own errors.

The concept of the doctor as the second victim rapidly gained attention within healthcare professions. Articles were published supporting Wu's (2000) observations of the affective impact on clinicians of being involved in clinical errors (e.g., Goldberg, et al., 2001; Hewett, 2001; Petronia 2006; Wears & Wu, 2002). Within the systems-based research into medical errors undertaken at that time, Hewett (2001) posited that the healthcare environment does not fit into "neat categories" and that it is not helpful to view medicine as "almost an engineering process" (p. 483). Instead, he suggested that organisations should work towards alleviating the stress encountered by those involved in a SI. Subsequently, research was undertaken exploring the impact of SIs upon physicians (e.g., Aaraas, et al., 2004; Aasland & Førde, 2005; Lander, et al., 2006; Schwappach et al.; White, et al., 2008).

Waterman, et al. (2007) surveyed 3,171 doctors, who had been involved in incidents between 2003 and 2004. The doctors were from a variety of medical specialities, with an average age of 49 years and an average of 16 years in practice. They divided their participants into three groups: those who had been involved in SIs, those who had been involved in less harmful incidents and those who had been involved in near misses (events which almost happened and would have been SIs if they had). Their results showed that those involved in SIs reported more anxiety, sleep disturbances, reduced confidence and loss of job satisfaction than those in the other groups. They stated that their findings indicated that the “impact of medical errors upon practicing physicians is substantial” (Waterman et al., 2007, p. 471). They also reported that their participants overwhelmingly indicated that their employing organisations did not adequately support them in coping with the stress they experienced after the error. Interestingly, Waterman, et al. (2007) found that 82% of their cohort were interested in undergoing counselling after being involved in a medical error, although many of them reported perceived barriers towards doing so, which will be discussed later.

Denham (2007), interviewed a number of safety experts, asked them if they thought that second victims were experiencing a psychological emergency. Most of them agreed, with one stating that “We have to take care of them” and another saying that second victims need help to manage “what has got to be just a terrible, terrible, terrible unprecedented tragedy in their lives” (p. 111-112). Several suggested that counselling should be offered as a matter of course rather than as an afterthought.

Further research confirmed that second victims manifest wide-ranging symptoms of psychological distress. Most often reported were anxiety, depression, shame, guilt, loss of confidence, sleeping difficulties, intrusive thoughts, flashbacks, reduction in work satisfaction, fear of making another error and job-related stress (e.g., Harrison et al., 2015; McLennan et al., 2015). Burlison et al., (2016) found that second victims’ distress can lead to absenteeism and their leaving the organisation where the incident occurred, with significant numbers leaving medicine altogether. It was proposed that the symptoms that second victims report are highly suggestive of PTSD (e.g., Dekker, 2012; Harrison, 2014; Wu 2000). The link between the described symptoms and PTSD will be discussed in the next section.

2.4 PTSD

PTSD is diagnosed when an individual has experienced or witnessed a violent or accidental event that could result in injury or death and develops severe and long-lasting psychological distress (NICE, 2018; Shalev et al., 2017). The individual repeatedly re-experiences the event and attempts to avoid any trauma-related stimuli. They will often experience worsening negative thoughts about themselves and the world and will find themselves in a state of continued arousal or hypervigilance. These symptoms are persistent and can cause the individual stress and functional impairment (DSM-V, American Psychiatric Association, 2013; NICE, 2018). The affective symptoms that second victims describe are prevalent in PTSD, the commonest being depression, generalized anxiety disorder (GAD), panic disorder, and substance misuse (e.g., Fullerton & Ursano, 2005; Kessler, et al., 1995). Dekker (2012) proposed that a sense of helplessness is also a function of PTSD. NICE (2018) stated that the severity of traumatic experiences correlates significantly with the manifestation of PTSD symptoms. A similar relationship between the degree of psychological distress and the severity of SIs was identified in Waterman et al’s (2007) exploration of the psychological impact on second victims.

Dekker (2013) posited that the sense of helplessness that second victims experience is causal in the development of PTSD. He suggested that in cases where second victims can do nothing to change their error, they become helpless. The mind is imprisoned in this helplessness and, consequently, is unable to process the error. Instead, the psyche re-runs the experience through dreams, flashbacks and intrusive thoughts, unable to distinguish that the error was experienced in the past. Scaer (2014) reiterated the role of helplessness in trauma, asserting that it is a “universal state in trauma victims” (p. 61).

Research into traumatic experiences shows that most of those affected recover within approximately one month (Ehlers & Clarke, 2000) and therefore, by definition, do not have PTSD. However, those with persistent symptoms are diagnosed with PTSD. PTSD is a chronic disorder with associated psychological and social disorders, from which some never recover (Bisson, et al., 2007; Kessler et al., 1995). Treatment for PTSD improves the prognosis, with clinical studies showing that CBT for trauma is highly effective (e.g., Bisson et al. 2007; Harvey et al., 2003; Wilson et al., 2012). In contrast, it has been found that untreated individuals with PTSD can still manifest symptoms several decades after the traumatic event (Bichescu et al., 2005).

An additional concern is that a co-morbid psychopathological link between PTSD and suicide has been identified. This correlation was first discovered in veterans from the armed forces (Bullman and Kang, 1994) and has subsequently been identified in other groups (e.g., Panagioti et al., 2009; Tarrier & Gregg, 2004). Gradus et al., (2010) found that the association between PTSD and completed suicide was strong, even after controlling for psychiatric and demographic variables. Recommendations for treatment of those suffering from PTSD with suicide ideation is a specialised combination of risk management and suicide and trauma focused therapy (Bryan, 2016).

Strobl et al., (2014), concerned by a number of reported suicides of clinicians who were under investigation after being involved in SIs, attempted to discover the frequency of second victim suicides by surveying all healthcare organisations within one UK region. Most of the organisations reported that they did not keep a record of the number of suicides of clinicians being investigated following SIs. The remaining organisations failed to answer the question relating to second victim suicides. The researchers also asked if policies were in place that outlined support for clinicians who had been involved in a SI. The responses highlighted that there were national policies in place, such as the NHS Health and Well-being Improvement Framework (Department of Health, 2011) and The National Suicide Prevention Strategy for England (2012), the second of which includes a section on doctors and nurses as an occupational group at high risk of suicide. However, the researchers reported finding little evidence of these policies being effectively disseminated. Strobl et al., (2014) concluded that “suicides associated with incidents and investigations do happen, but the extent of the problem essentially remains hidden” (p. 25). This is alarming because it suggests that the individuals concerned were invisible to the system and were therefore unlikely to have received support for the distress they were clearly experiencing. The incident reporting systems in the UK are understandably focused upon patients’ and carers’ wellbeing, incident investigations and prevention,. However, there is little reported about the prevalence of doctors involved in SIs. This will be discussed in the next section.

2.5 Prevalence of Second Victims as Originally Defined

In America, it is estimated that almost half of all healthcare professionals will be involved in a SI at some point in their careers (Seys, et al., 2012). Although there are no equivalent figures available for the UK, the NHS reported 69,754 SIs that caused moderate harm, severe harm and/or death between April 2019 and March 2020 (NaPSIR, 2020). As there is evidence that the emergence of second victims' symptoms correlates with the severity of the incident, (NICE, 2018; Waterman et al., 2007) it is likely that a sizable proportion of UK health-workers have significant mental health issues that are impacting upon their work and personal lives (e.g., Burlison et al., 2016; Edrees et al., 2011; Harrison et al., 2015; Seys et al., 2012).

2.6 A Problematic Shift in the Definition of the Second Victim.

A survey of clinical and non-clinical staff undertaken in the USA by the University of Missouri Health Care (UMHC) found that one in seven members of staff had experienced a "patient safety event" in the previous year that caused problems such as anxiety and depression (Scott et al., 2009, p. 325). From these raw data, a "consensus definition of second victims" (Scott et al., 2009, p. 326) was drawn up:

> "A second victim is a health care provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event." (p. 326).

This expanded the original definition of the second victim to encompass all incidents, ranging from those causing patients little or no harm to SIs, as well as including unforeseen outcomes not related to clinical error. It also incorporated non-clinical staff such as managers, administrators and social workers (Scott et al., 2009).

It has been recognised for some time that a variety of healthcare professionals can experience stress and trauma because of the acuteness and the frequency of human suffering they witness as part of their everyday work (e.g., Aiken et al., 2002;

Pearlman & Saakvitne, 1995). Nimmo and Huggard (2013) referred to it as an "occupational hazard" (p37). This impact has also been found in other professions, including the armed forces and the emergency services (e.g., Divilly et al., 2008; Murphy et al., 2015). Fisher (2003) described this as vicarious or secondary trauma and suggested that the cumulative effect of repeated exposure to others' suffering can damage an individual's connectivity with humanity and induce compassion fatigue and burnout (Fisher & Abrahamson, 2002; Nimmo et al., 2013). Dearmin (2020) stated that it is the empathetic strength which drew clinicians to healthcare in the first place that makes them vulnerable to the "ripple effect" of their patients' trauma (para. 5).

However, the type of trauma experienced by those who were within the criteria of the original definition of the second victim is very different from vicarious trauma (Dearmin, 2020; Wu, 2000). The original definition of the second victim referred to doctors who are traumatised because a patient whom they set out to protect is harmed or killed, in error. In addition to the "complicated stew of emotions" (Dearmin, 2020, para. 6) shared with those experiencing vicarious trauma, the originally defined second victims also invariably repeatedly ruminate over whether their actions or omissions were causative. Dekker (2012) clarified that feeling intensely responsible for a SI is "one of the most potent and particular contributors to the symptoms of second victimhood: guilt, trauma and depression – the sense that one should have done something but did not" (p. 88). This creates a degree of moral distress that is unique to second victims, as originally defined. Dekker (2012) continued, "it is precisely the role of contributor that fills second victims with guilt and remorse. It creates an insufferable tension with the professional mandate. They were there to heal not to kill" (pp. 2-3). The change of the parameters of the definition is particularly important because it now includes individuals with a range of types and degrees of trauma or stress and this could deflect attention away from those who met the original criteria - the group who have been shown to be at heightened risk of developing chronic PTSD (Dekker, 2012; Harrison, 2014; Wu, 2000) and, as such, at additional risk of reduced mental health and suicide (Gradus et al., 2010; Panagioti et al., 2009). They are therefore individuals who it is recommended require urgent, specialist psychological and medical interventions (Bryan, 2016).

The new definition of the second victim was generally accepted and researchers in the field recruited cross-professional groups of participants (i.e. not just doctors) who had experienced trauma or stress related to a wide range and severity of clinical events. The sheer numbers of those who now qualified as second victims surprised the researchers (Scott, 2009). For example, in the NHS, the new definition would potentially include nearly one million healthcare workers per annum, with the severity of incidents ranging from errors in administration paperwork, such as, a patient’s discharge letter being delayed, to the unexpected death of a patient.

Under the auspices of the UMHC, Scott et al. (2009) set out to understand the second victim, employing the new definition. They conducted 31 interviews with participants using a 25 item interview schedule, analysing the data for themes. They identified six stages that they believed demonstrated a “natural history of recovery” (Scott, et al., 2009, p325). They posited that this post-event trajectory of recovery is predictable and, as such, could be used to facilitate recovery.

The six stages towards recovery that Scott et al. (2010) proposed were: (1) chaos and accident response, where the researchers reported chaos and internal and external turmoil and a rapid need to discover what had happened; (2) intrusive reflections, which was described as re-enactment and ‘what if’ questions; (3) restoring personal integrity, when the clinician is fearful that they have lost the trust of colleagues and that others will perceive them as the “weak link” (p. 4) in the team. (The authors state that these first three stages can happen simultaneously); (4) enduring the inquisition, which refers to any investigations that might take place, although, in the UK, it is only the most serious incidents that are investigated; (5) obtaining emotional first aid, including seeking emotional support but not knowing where to go; (6) moving on, consisting of three possible eventualities, which were dropping out, surviving or thriving. On the basis of their findings, Scott et al. (2009) advised that organisational programmes of support should be created.

2.7 Programmes of Support

In response to the above paper, the research effort focused upon creating organisational wide tools and programmes to accommodate the large numbers of second victims identified using the new definition. Scott et al., (2010) created a three-tiered programme of interventional support, the first tier of which was pre-emptive. Department leaders and colleagues receive basic awareness training to provide emotional first aid to all staff who had been involved in “emotionally trying case types” (p. 236). They estimated that this would be sufficient for 60% of second victims.

It is unclear what prompted a referral to the second tier, as the only detail given is that “previously identified second victims” would receive “guidance and nurturing” from “specially trained peer supporters” (p. 236) within tier two. The details of what this support consists of are also not clearly documented, but Scott et al., (2010) did state that the peer supporters could refer the second victims to patient safety experts for support during investigations. The peer supporters in this middle tier would also provide debriefing for groups involved in unexpected events. The researchers posited that this tier would meet the needs of another 30% of the second victims.

The third tier of support is for the remaining 10% of second victims, whose emotional stress is deemed to be beyond the expertise of the peer supporters. This tier involves referral to support services such as “chaplains, employee assistance programme personnel, social workers, and clinical health psychologists” (Scott et al., 2010, p. 237). These professionals are assumed to be available within every organisation. The authors provide insufficient information to establish how many of those who would have fulfilled the original definition of a second victim fall into each tier, but, given the complexity and severity of the psychological impact reported in the research prior to the change in definition, (e.g., Aaraas et al., 2004; Aasland et al., 2005; Lander et al., 2006; Schwappach et al., 2009; Waterman et al., 2007; White et al., 2008), it could be postulated that the majority would be in this third tier.

Another systemwide peer support programme for healthcare workers involved in incidents was the RISE Programme (Resilience in Stressful Events). RISE was developed and piloted at Johns Hopkins Hospital in America (Edrees et al., 2016) and consisted of staff being offered a telephone peer listening service followed by signposting to other services, (including counselling), if felt to be necessary. A total of 119 calls were received over one year, mainly from nurses; only 4% were related in any way to clinical incidents. Although the RISE programme is described as a peer support service, it is actually adapted from the Critical Incident Stress Debriefing (CISD) operational manual, further detail of which are given below (Edrees et al., 2016). The peer supporters, who came from a variety of healthcare backgrounds including non-clinical workers, received six hours of training in active listening and information about signposting to other services. The value of RISE in supporting second victims is currently unclear as the evaluation the researchers conducted was mainly about the experiences of the peer reviewers, rather than of the service users (Edrees et al., 2016). However, Plews-Ogan et al's (2016) participants reported that, whilst their colleagues who provided them with peer support were well meaning, their tendencies to minimise errors were not helpful.

Other researchers recommended debriefing as a method to provide mass support for second victims identified under the new wider definition (e.g., Harrison et al., 2017; Nocera et al., 2017). Debriefing includes a review and discussion of individual or team performance, identifying error and provides learning and emotional support as well as developing plans for the future (Harrison et al., 2017; Nocera et al., 2017). Debriefing is traditionally used for helping individuals or teams in the military and emergency services after a mass disaster, so it is a part of emergency planning and generally follows the CISD Operational Manual (Mitchell & Everly, 2001). Other forms of debriefing are used elsewhere in medicine especially in medical scenario simulation training, such as the healthcare simulation after-action review used in accident and emergency departments (Abulebda et al., 2019).

The recommendations for the use of debriefing in the event of a SI include either informal debriefing with an untrained colleague (Norcera et al. 2017) or debriefing by a trained facilitator (Harrison et al., 2017; Sacks et al., 2001), following the CISD operational manual (Mitchell et al., 2001), This manual follows a seven step approach which includes listening and reassurance (Mitchell et al., 2001).

Much of the research related to debriefing for second victims was designed to ask participants how they felt about debriefing (Sacks et al., 2001; Harrison & Wu, 2017; Nocera & Merritt, 2017), as opposed to exploring what interventions participants might have chosen had they been given a free choice. Having information about second victims' preferred interventions might be important in designing support services that they could relate to. For instance, Tan (2005) surveyed anaesthetists in regard to debriefing after a SI and 54% of responders (N=149) agreed that debriefing would be beneficial, if they were to become second victims. However, 36% of the responders had never personally experienced debriefing, which means that their responses have to be interpreted with caution. It is also unclear how many respondents had experienced being a second victim.

2.8 Review of Programmes of Support

Debriefing and peer support are often used elsewhere in medical practice for alleviating the everyday stressors which are often experienced in healthcare, (Maudsley & Strivens, 2001; Krogh et al., 2016), so clinicians are familiar with them. As most of the researchers in this field came from clinical backgrounds, this familiarity may explain why the researchers were drawn to these two forms of support. Indeed, research has demonstrated efficacy of both peer support and debriefing in providing shared understanding, emotional and social support for reducing work stress, burnout (e.g., Gunasingam et al., 2015; Peterson et al., 2008) and vicarious trauma (Manning-Jones et al., 2016). Therefore, it is unsurprising that these models of support have been enlisted under the expanded definition of second victims. However, the research undertaken within the original definition of the second victim clearly identified individuals suffering from PTSD (e.g., Fullerton & Ursano, 2005; Hughes & Nelson, 1995; Kessler et al., 1995) and neither peer support nor debriefing are recommended treatments for individuals who have PTSD (DSM-V, American Psychiatric Association, 2013; NICE, 2018).

NICE (2018) explicitly states that any form of debriefing, including CISD, should not be carried out as a psychological intervention to ameliorate the experience of PTSD symptoms, citing evidence that debriefing does not relieve trauma and, as such, would be ineffectual and may delay access to other interventions with greater evidence of benefit (NICE, 2018). Furthermore, CISD can increase the risk of PTSD, possibly because it requires those being debriefed to re-experience the event and to make their memory of the event more vivid. (Devilly & Varker, 2008). Given that Brewin et al., (1999) found that re-experiencing and arousal symptoms in individuals were the best predictors of PTSD, this provides an argument against the indiscriminate use of debriefing to support second victims.

Originally, NICE (2005) also explicitly stated that peer support should not be used with PTSD, then, in response to “limited but compelling” feedback from PTSD sufferers, it was included in the NICE guidance for PTSD as a means to provide shared experience support (NICE, 2018, p22). with the qualification that it should: “be facilitated by people with mental health training and supervision, be delivered in a way that reduces the risk of exacerbating symptoms and provide information and help to access services” (NICE, 2018). Furthermore, both NICE (2018) and the National Centre for PTSD in America (Schnurr & Friedman, 2008) clearly state that the optimal treatments for persistent PTSD are evidence-based psychological interventions, most notably cognitive processing therapy, trauma-focused CBT, narrative exposure therapy and prolonged exposure therapy

In terms of second victims, debriefing and peer support will probably meet the needs of many of those falling within the expanded definition, such as cases of workplace stress, burnout and vicarious trauma. However, based on the arguments outlined above, these two currently adopted models of support are not suitable for those meeting the original definition.

This raises the question of why evidence-based psychological interventions have not been recommended for second victims. A possible explanation is that most researchers did not directly ask participants if they thought they might benefit from psychological interventions. In the few studies where second victims could provide free text about their thoughts regarding psychological intervention, some second victims did indicate they might seek therapy, but in such small numbers that they were not considered to be of statistical significance when compared to other methods of support (e.g., Han & Bohnen, 2017; Ozeke et al., 2019; Scott et al., 2020).

However, obtaining second victims' views on seeking therapy from trained mental health professionals (e.g., psychologists, psychotherapists or counsellors) may not simply be a case of asking an open question. Ullström, et al., (2014) interviewed 21 healthcare professionals who had experienced being involved in a clinical incident. Whilst they used Scott et al's (2009) semi-structured interview script in the first instance, they divided some of the questions into open-ended sub-questions that included one about the participants' need to talk about the error. The participants who responded did not mention seeking therapy from a psychologist or other talking therapist, even though one individual likened the experience of being involved in a SI to "mourning." This suggests that psychological support does not automatically come to mind for clinical healthcare professionals in general, despite the intense emotional distress they experience and the overwhelming evidence of its benefit in treating trauma in other professional groups, such as the emergency services and armed forces (e.g., Divilly et al., 2008; Murphy et al., 2015).

Denham (2007) proposed five rights for second victims: treatment that is just, respect, understanding and compassion, supportive care and transparency. He stated that “Our caregivers are entitled to psychological and support services…We must take a systematic approach to delivering this care in as professional and organized a way as we would in treating any other patient” (p. 116).

In the NHS, it appears that neither Denham’s (2007) vision or NICE guidelines (2018) are followed. The main criticism from Ullström et al.’s (2014) participants was that there was no structured support in place for those involved in SIs. Therefore, if the NHS does not provide a clear, specialised structure of psychological support for second victims, then it is little surprise that it would not occur to healthcare professionals to choose it when asked opened questions Perhaps, awareness training of what psychological interventions mean and the potential positive outcomes of seeking specialised help might be beneficial. There are other potential barriers to the seeking of psychological support by doctors and other medical professionals, which will be discussed next.

2.9 Potential Barriers to Seeking Psychological or Other Support

2.9.1 Stigma

In an article about the barriers that prevent doctors from seeking psychological help, the Guardian Newspaper reported the case of a “brilliant young psychiatrist” who killed herself and her baby, whilst experiencing violent delusions caused by bipolar affective disorder which she had kept secret from her employer and most of her colleagues (Carpenter, 2014). The doctor's husband said she was terrified of being "found out", because she believed she would lose her job.

During the inquest, the stigma of mental illness among clinicians in the NHS was cited as a contributing factor, as were inadequate NHS occupational health services. A further significant factor was that both her husband and their friend, who was a psychiatrist who she had confided in informally, relied on her insight as a doctor to alert them to any changes in her mental health, rather than perceiving her as a patient in need. Although there is no evidence that this doctor was a second victim, this tragic example illustrates well the stigma surrounding doctors with mental health issues, which is likely to contribute to second victims' reluctance to seeking help from appropriately qualified professionals.

2.9.2 Fear

Fear is negatively correlated with the likelihood of an individual seeking help from a mental health professional (Kushner & Sher, 1991). Fear may therefore be another factor which deters second victims from seeking psychological help, although there is no direct evidence of this. However, research suggests that doctors often delay seeking help when suffering from a mental health illness (Kay et al., 2008). Brooks et al. (2017) found supporting evidence that doctors are fearful due to the shame of mental illness, and concern about what might happen to their careers and reputations. Spiers et al.'s (2017) participants cited mistrust of the robustness of the confidentiality and privacy of the services provided, as well as internal and perceived external stigma. One participant reported to Brook et al. (2016) that they were "at death's door" before they sought professional help because of a fear of disclosure. Clearly, the NHS's obligation to ensure patient safety is paramount and the ethical tightrope that medical organisations have to navigate is difficult, but the wellbeing of doctors is also important.

2.9.3 The Doctor as Patient

Doctors do not make good patients (Strang et al., 1998). Studies have shown that rather than following formal NHS patient pathways, doctors often self-medicate and seek informal "corridor consultations" as solutions to health issues (Davidson & Schattner, 2003; Rennert et al., 1990). This may seem contrary to the fears of disclosure outlined previously, but informal consultations are not officially recorded and therefore are less likely to be reported.

Thompson (2001) suggested that the culture of medicine encourages an image of invincibility among doctors and therefore a denial of ill health. This might explain Davidson and Schattner's (2003) finding that 71% of their doctor responders described themselves as embarrassed when seeing another doctor. They postulated that presenting to a peer means they are publicly robbed of their invincible identity. Brooks et al. (2017) suggest that the blurred experience of being a doctor and a patient is disempowering because of the different expectations of each of these roles within medical consultations and the difficulty of finding themselves with dual perspectives.

2.9.4 Time and Accessibility

A commonly reported barrier to seeking psychological help is that doctors are reluctant to take time off, because of work pressures and obligations to their colleagues (Brooks et al., 2017: Iversen, Rushforth & Forrest, 2009). Whilst this is one explanation, others have found that doctors do not seek help because of the inertia they experience as a consequence of their mental ill-health (Spiers et al., 2017).

Another documented barrier is difficultly in accessing psychological support. Many doctors stated that they did not know how to access it and are unsure of where to go (Harrison et al., 2013; Joosten et al., 2014; Scott et al., 2009; Ullström et al., 2014). Grissinger (2014) suggested that second victims are abandoned by the culture within medical organisations.

In fact, in the UK, there are national services available to doctors that provide psychological support from psychologists and other therapists. Albeit not specifically for second victims, the British Medical Association (BMA) provide a 24/7 telephone counselling service to doctors; structured video sessions are also available. There are also a large number of private therapy services claiming to specialise in the mental health of doctors that are easily found via internet search engines. One participant in a recent research interview may have provided some insight into the reluctance towards seeking counselling as a second victim. He recommended it enthusiastically for others but said of himself, "…it is such an awful, lonely, emotional journey. I would certainly struggle to articulate just how fucking awful it is" (McNamara, 2018, p. 895). Perhaps, we still do not know enough about the clinicians who have been involved in SIs and who are struggling with mental health issues as a result. I will explore this in the next section.

2.10 “Second Victim: After all, what is this?” (Tartaglia, & Matos, 2020)

Research into the second victim phenomenon has recently returned to the issue of the impact upon medical staff when they are involved in a SI and are exhibiting psychological distress (i.e.: they fall into the original definition of second victims). For instance, Baas et al. (2018) received 683 responses to their national survey that sought to understand the impact of SIs upon Dutch obstetricians and gynaecologists. They found that 12% of their responders indicated they had symptoms of PTSD and 30% of the cohort felt they would benefit from counselling. Robertson (2018) conducted a review of the literature and concluded that physicians “feel alone in their attempt to heal” after being involved in a SI (p. 1) and recommended a need for provider counselling services. Discussions also continue in medical journals about the subject of the second victim. Ozeke et al. (2019) expressed concern for the psychological wellbeing of those doctors who have been involved in a SI and called for solutions to the problem. Headley (2018), a freelance writer for a patient safety journal, asked if second victims were getting the help that they need and suggested that the medical profession’s response towards calls to provide support for them is still in its infancy.

2.11 Rationale for This Study

As outlined above, the past research into the second victim phenomenon has predominately been conducted by healthcare professionals, with the focus of these studies being upon identifying symptoms, creating a diagnosis and seeking solutions. They have largely followed the medical model of research via the perspective of empirical lenses. Perhaps, as professional carers they had a sense of responsibility, as illustrated by one of Denham’s interviewees who stated, “but we have to take care of our own" (p. 111). Thus, much is believed to be known, within the medical model, about second victims. Much is also believed to be known about how to treat the second victim, from a healthcare system approach. Yet, there is a paucity of knowledge about the phenomenon of the second victim itself from a psychological perspective and, because of this, there is a possibility that unevidenced assumptions about the second victim phenomenon are being made.

It is interesting that, after all these years of research and programme development, the same questions are still being asked about the second victim phenomenon. Perhaps it is because they cannot be answered without an understanding of the second victim phenomenon itself – an exploration of what it is to be a second victim, from the perspective of the second victims. This was recently recognised by Tartaglia et al. (2020) who emphasised in their discussion article, "Second Victim: After All, What Is This?", the need to further explore the nature of the second victim phenomenon (p. 2).

My rationale for undertaking this study is to attempt to meet this need to further explore the nature of the second victim, not by using empiricism nor by way of medical modelling, but instead from a new perspective, by exploring the phenomenon through the accounts of those who have personally experienced the phenomenon, the second victims themselves. The lived experiences of those who believe they have become second victims after becoming involved in a SI are uncharted and therefore the psychological structure of the phenomenon is undetermined: we do not know the psychological nature of the second victim phenomenon.

2.12 Aim of Study

New services in the NHS need to be based upon existing research, guidance, policies or proposals in order to ensure they have robust justification for implementation. The aim of this study is to contribute new information to the field of the second victim, as defined by Wu (2000), by providing an in-depth account of the second victim phenomenon, as given by the second victims themselves. My aim is to do this using Giorgi's (2017) DPA method. I believe that by remaining faithful to the participants authentic descriptions of their experiences of being involved in a SI, the phenomenon will be revealed, and counselling psychologists, the wider psychological community, doctors themselves and the medical profession as a whole will truly have the opportunity to discover what second victims need to help them to heal, through the development of specialised services.

I believe that an improved understanding of the second victim phenomenon would help to ensure that any new specialised service is designed in a way which would provide the maximum benefit to the second victims themselves – which in turn would benefit the NHS as a whole. In addition, this research would potentially be informative for psychology clinicians working in occupational health services, as second victim are often referred there. Therefore, the overall aim is to heighten awareness of the second victim phenomenon and the related complex psychological impact it can impose, and to enable the identification and appropriate treatment and support for second victims, should they encounter them.

2.13 Research Question

What is the lived experience for doctors when they are involved in a serious incident? A descriptive phenomenological analysis.

CHAPTER 3

METHODOLOGY

3.1 Overview

Denzin and Lincoln (2011) stated that a researcher “approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that they examine in a specific way (methodology, analysis)” (p. 11). This provides a lens through which the researcher can view their study material. It is imperative that a researcher understands their personal ontological and epistemological positioning from the outset, in order to ensure that their theoretical framework and underlying assumptions are reflected in the chosen method of enquiry and are consistent with their aims. Research is not aimless; it has purpose and that purpose must also be made clear, in order to demonstrate the ethical rationale for a study. My own positioning has emerged alongside my identity as a counselling psychologist, with my training being highly influential in my research. This chapter provides a description of my ontological and epistemological stance and how my training influenced this. It describes the method of enquiry undertaken and how it directly aligns to this philosophical positioning. In addition, it details the ethical considerations and reflexivity strategy undertaken and implemented throughout the study. It includes the process undertaken for identifying and recruiting the participants, the materials used, the procedure, the data collection and the analysis.

3.2 The Influence of a Counselling Psychology Identity Upon the Research Methodology

Counselling psychology practitioners prioritise regard and respect for an individual’s idiosyncratic experiences and perspectives, over seeking an external truth. As such there is a commitment to pursue a deep exploration of the human subjective experience, as it is believed that within it lies an individual's strengths and psychic pain which, once unveiled, has the potential for restoration (Bury & Strauss, 2006). The counselling psychology discipline has founded its competencies upon explicit, philosophically-oriented values (Goldstein, 2009), that honour an other's agency, autonomy and right to confidentiality in a way that Cooper (2009) described as "ethics in action" (p. 120). At its bedrock is a commitment and open-mindedness to a broad spectrum of humanistic approaches in the endeavour to alleviate human psychological and emotional suffering (House and Feltham, 2015). In the UK, many counselling psychologists work within the NHS whilst candidly embracing a non-medical ontology and questioning prevailing orthodoxies such as the "categorisation of distress", (Milton et al., 2010, p. 62).

It is, perhaps, therefore not surprising that the ethics and philosophy of counselling psychologists in therapeutic practice, are also evident in counselling psychology research. The discipline actively encourages critical thinking and continuous attention to building knowledge through research. This is, in line with their humanistic values, predominately achieved via qualitative methodology because it enables scrutiny of the subjective, inner, interpersonal and emotional experiences of participants (House et al., 2015).

3.3 Ontological and Epistemological Positioning

Coppola and Mento (2013) stated that every qualitative researcher, in their endeavour to discover knowledge, is "animated by that epistemophilic drive" (P. 3). However, this drive is powered by a compendium of philosophical perspectives and the researcher is required to know their own epistemological and ontological positioning, prior to embarking upon a research journey.

It is considered to be essential that qualitative researchers state their philosophical stance in regard to the type of knowledge that is being pursued, in order to demonstrate congruence with their research methodology and research objectives (Ponterotto, 2005). It improves the quality, rigour and transparency of the research process (Kasket, 2012). Further, the philosophic link between epistemology and ontology provides others with the conceptual basis from which the research topic has been studied (Holroyd, 2008). The philosophy relates to the researcher's ontological and epistemological views of knowledge, their beliefs about the nature of reality and how that reality is known respectively and their axiological research values (Kasket, 2012). It is these beliefs that steer the qualitative researcher to opt for a particular research method.

In terms of my ontological stance, I believe that there is a reality independent of human consciousness, but that the individual's observation of the external world is diffused by their own perceptual lenses. Thus, my ontological positioning is that of a critical realist. My epistemological stance is phenomenological; I subscribe to the notion that it is through an individual's subjective descriptions of their lived experiences that phenomena can be known (Giorgi, 2009). In relation to axiology, I acknowledge my own values, but I believe that I can hold any presuppositions in abeyance and enlist bracketing (Giorgi, 2009) in order to see the essence of a phenomenon from an other's perspective (Finlay, 2009; Gearing, 2004).

Thus, the formulation of my research question; 'what is the lived experience for doctors when they are involved in a serious incident?' was steered by my philosophical positioning. That is, I believe that serious incidents are a medical reality, but how they are experienced depends upon the subjective lens of the experiencer's perspective, in this case, medical doctors, and that it is within their experiential descriptions that the essence and structure of the second victim phenomenon resides.

Maintaining this ethos, I sought a method of enquiry that would allow me to focus upon my participants’ experiences, as given, and remain as close to their authentic descriptions as possible, within a psychological frame. As previously addressed in the literature review, there is a plethora of research into the second victim phenomenon, but none of the studies include the experience, as given by the second victim, nor are they conducted exclusively from a psychological frame. To achieve this, I needed a method that provided the means for me to keep any of my own assumptions in strict abeyance. I chose DPA, following Georgi (2009). In order to explain my choices, I will next provide a brief history of phenomenology, DPA as a psychological method and my rationale for using DPA.

3.4 A Brief History of Phenomenology

All Phenomenological principles have their aetiology in the philosophical concepts of Edmund Husserl (1900/1970), a German philosopher. Phenomenology is the study of human experience, the way in which things are experienced and perceived, by the conscious mind.

A key tenet of Husserl’s (1900/1970) phenomenology approach is intentionality, that is, that consciousness is always conscious of something other than itself. According to Husserl (1900/1970), this means that experience is synthesized through consciousness. Zahavi (2003) elucidated: “One does not merely love, fear, see, or judge, one loves a beloved, fears something fearful, sees an object, and judges through a state of affairs” (p. 14).

Husserl (1900/1970) called this the “noema-noesis correlation”: as consciousness is turned intentionally out towards one object or another, it actuates the correlation between what is experienced (noema) and the way it is experienced (noesis). He believed that there are common aspects among all humans within the noema-noesis correlation, that provide the means to discover the structure or essence of a phenomenon that is universal (Finlay, 2011). Husserl (1900/1970) proposed that this is achieved by transcending our natural attitude towards viewing experiences through lenses influenced by our individual history, culture and context (Georgi, 2009). Our natural attitude is that through which we live in the “lifeworld” (Husserl, 1900/1970); how things appear to us in our conscious as a part of everyday life. Husserl (1900/1970) believed that it is possible for us to consciously put our own preconceptions into abeyance (epoché or bracketing). Fink (1972) stated that this is the method we use to, “free ourselves from the captivity of the unquestioned acceptance of the everyday world” (p. 41). As a result of bracketing, the phenomenon stands out from the lifeworld and we are able to question it’s “whatness” (Todres & Holloway, 2004, P. 84).

Husserl’s (1900/1970) student, Martin Heidegger (1962) whilst agreeing that phenomenology has its focus upon the experiences of humans as they live them, rejected Husserl’s (1900/1970) view that it was possible to transcend one’s own assumptions and instead proposed that we can never share an individual’s experience. Instead, Heidegger (1962) proposed hermeneutic phenomenology which focuses upon the researcher’s interpretations of the participants’ experiential descriptions, to which they then assigned meanings (Parahoo, 2014). This meaning making emerges from the researcher’s empathic understanding of the participants’ perspectives, accompanied by their questioning and building their own interpretations of the accounts; it is here that they move beyond what is given (Smith, Flowers and Larkin, 2009). There are a number of different ways that phenomenology is used in research. In psychological research, two broad categories of phenomenological analysis are most commonly used: descriptive and interpretive (DPA and IPA). DPA is derived from Husserl's (1900/1970) concepts, whilst IPA is adapted from Heidegger's (1962) teaching.

Arguably, one of the noteworthy differences between the DPA and IPA perspectives is an attitudinal one (Giorgi, 2009). In DPA, the researcher does not go beyond the description of what is given by the participant; instead, they translate their descriptions into psychological discourse that reveals the phenomenon within. Georgi (2009) explained that language is used, "to articulate the intentional objects of experience" (p, 89). In IPA, the researcher immerses themselves into the description of the phenomenon and emerges with a phenomenon that has been blended from the researcher's understanding of the participants' descriptions (Wonjer and Swanson, 2007). Thus, in IPA, according to Georgi (2009), the articulation of the intentional objects of experience is assisted by the use of factors not provided by the participants but, instead, by way of the researcher's assumptions. In this sense, it could be said that the researcher is a co-creator of the phenomenon being studied.

3.5 DPA as Psychological Research

Amedeo Giorgi (2003; 2009) is credited with developing Husserl's (1900/1970) phenomenological concepts into a method of psychological research (Applebaum, 2011). Giorgi (2009), as a psychologist, wanted to modify Husserl's (1900/1970) method in order to allow the exploration of a phenomenon from a psychological perspective and to, “meet scientific psychological criteria” (p. 95). He achieved this by moving away from the transcendental perspective created by Husserl (1900/1970) and instead designed procedural steps of analysis to be followed. The researcher still follows much of Husserl’s (1900/1970) original techniques, such as bracketing, but the attitude of reduction is psychological rather than philosophical. Therefore, the outcome is changed and captures the “typical” (Georgi, 2017, P. 181) psychological essences of a phenomenon rather than the universal essences sought within philosophy.

3.5.1 Rationale for using DPA

My rationale for using DPA is twofold. Firstly, DPA aligns strongly with my own epistemological and ontological positioning. DPA accepts the reality of a situation, in this case medical error, but also subscribes to the notion that subjective experience is the means by which that reality is understood (Georgi, 2009). Secondly, I believe that DPA is unique in its endeavour to quieten all but the participants’ voices, including the researcher’s, throughout the research enquiry in order to allow the phenomenon to emerge from the patterns of experiences, as given. The researcher’s role is also distinctive; they are not required to interpret, verify or construct their participants’ experiences; instead they perform an act of discovery, capturing the phenomenon and re-expressing or translating it into psychological formulations (Broomé, 2013).

DPA is not designed to come to a consensus about how all individuals see the world, but instead it prioritises each individual’s unique perspective of the world (Maltby et al., 2015). Through Giorgi’s (2009) DPA process, I hoped to be able to understand the experiences of the second victims, the “textures of what it is like to be there.”

(Todres et al., 2005, p. 117). DPA does not endeavour to deduce the meanings of the subjective lived experience by enlisting external theory (Finlay, 2011). Any ambiguity identified is not clarified because it is the richness of the description, rather than any "speculative factors" that is of interest (Giorgi, 2009, p. 127). This is in contrast to all the of the previous research studies, of which I am aware, undertaken into the second victim phenomenon. I believe it is important to take a different direction because the experiences of second victims are different from those of clinicians who experience other types of trauma in their careers and who have also been included in this area of research in recent years. It could be said that, because of this, the second victims as originally defined are hidden and their needs are not being understood or addressed. Giorgi's DPA is a method of discovery and is ideal to seek out what is concealed (Broomé, 2013).

According to the British Psychological Society (2019), most counselling psychologists in the UK are members of the NHS workforce. This organisation's assemblage of healthcare professionals has traditionally worked predominately within the Cartesian dualist paradigm of the medical model (Mehta, 2011). Research into the impact of the experience of being a second victim has also predominately followed this positivist tradition. In the few instances where this was not the case, meanings from interpretations were still assigned. The methodological aim of my research was to step outside of this positivist tradition and instead explore the rich, subjective experiences of qualified doctors who have been involved in a SI using a phenomenological lens. The lived experiences of those who believe they have become second victims after being involved in a SI have remained uncharted and therefore, it could be argued, undetermined. To accomplish the aim of my proposed research and attempt to understand the nature of the second victim phenomenon, as it is actually given, was the rationale for choosing DPA. I followed Georgi's (2009) DPA methodology as he shared Husserl's (1900/1970) ambition to develop a rigorous application of deep exploration of the experiences of participants without the 'noise' of interpretation or other external factors.

3.6 Other Methodologies Initially Explored

I considered several potential methodologies in the early stages of developing this study. There is such a paucity of existing knowledge in relation to the perceptions that second victims have of being involved in a SI. Morrow (2007) suggests that, under such research circumstances, it is important to adopt an exploratory approach of enquiry, (Morrow, 2007). Below is a selection of methodologies that I explored.

3.6.1 Mixed Methods

I considered mixed methods, whereby two or more methods are used in a research study that yield both qualitive and quantitative data (Hall, 2013). I thought that this approach might fulfil a compromise between the empirical beliefs of my participants and my own aims to explore their experiences. However, I quickly discovered several controversies in the field, such as that mixed methods are not tenable within some philosophical positions, because they involve mixing contradictory views about reality (Holmes, 2006). Letourneau and Allen (1999) suggested that mixed methods research often retains much of its positivist aetiology, in that "cause and effect" analyses are still common. Indeed, Gidding (2006) went further and argued that mixed methods may have shifted, but within the positivist paradigm, rather than away from it. It was clear to me that the philosophical stance of mixed methods is still very much under debate, (e.g., Cresswell & Plano-Clark, 2007; Tashakkori & Teddlie, 2003). The philosophical positioning of methods used in research is an important consideration, as is the rationale for choosing one method over another if the rigour of the research is to be upheld. Cresswell, et al. (2007), highlighted that mixed methods are used to discover multiple perspectives, viewpoints and standpoints. It could be argued that this places mixed methods in opposition to my research aims and objectives; to discover the lived experience of being a second victim from the second victim’s own perspectives, viewpoints and standpoints. It was on the basis of the above, that I did not enlist mixed methods.

3.6.2 Narrative Analysis

I also considered Narrative Analysis (NA), because in this method researchers ask participants to tell of their experiences through meaningful stories. Sarbin (1986) stated that we live through the stories that we tell. However, the focus of NA is to explore the underlying ideologies that are within the stories that people tell and the wider culture that influenced the narratives (Stokes, 2003). This is achieved through various analytical processes, such as representing participants’ narrative through encoding its structure (Polkinghorne, 1995; Riessman, 2008). This was in opposition to my aim of examining the experiences of second victims, rather than to assign structure to their narrative. Furthermore, NA’s social constructionist philosophy also involves looking for meaning outside of the individual’s experience; again this does not align with the knowledge of the subjective experiences I am seeking (Polkinghorne, 1995).

After exploring these methods of research, I realised that they would not enable me to attain the knowledge I sought; the descriptions of the lived experience of those involved in a SI, as given, within which I believe resides the psychological essence of the phenomenon of the second victim. In addition, these other methods were at odds with the combination of my epistemological and ontological positioning.

It was at this point that I understood that I was seeking a phenomenon that was wholly within human experience. I was then able to decide that the most appropriate methodology to use was DPA.

3.7 Participants

3.7.1 Sampling Criteria

A purposive sample strategy of participants was sought for this research, in that I only considered qualified NHS doctors who had been involved in a SI (see table 1). All of the participants had experienced a SI, as defined by the NHS serious incident framework (2018); they had caused serious harm or death to a patient.

Table 1: Participants' Demographics

Pseudonym	Gender	Age	Years GMC Registered	Clinical Specialty
Simon	Male	53	28	Respiratory physician
Heather	Female	48	25	General practitioner for medical school students
Pamela	Female	45	21	Obstetrics and gynaecology surgeon
George	Male	61	34	General practitioner, specialist in emergency medicine
Julie	Female	63	36	General practitioner; specialist in medico-legal programme
Sophie	Female	56	32	Hospital dental surgeon
Laura	Female	38	15	General practitioner

3.7.2 Maximum Variation

I chose to use a maximum variation or heterogeneous strategy, following Giorgi et al.’s (2003) recommendation when using DPA, for a phenomenon that has little discerned about it. Giorgi et al. (2003) recommend maximum variation because it allows for the capture of a wide range of perspectives in relation to a phenomenon; it shines a spotlight on data that have previously been hidden. If the phenomenon is unknown, using maximum variation provides a holistic view of the data from different angles, thereby making it easier to identify the data that contain the common essences of the phenomenon from within the variation and allowing it to be extracted. Within this cohort there was a great deal of variation; other than their personal demographics, their clinical specialty experiences, the nature of the SI they were involved in, where the SI took place, how the NHS organisations handled it and the outcome of any investigations were also markedly different.

3.7.3 Inclusion Criteria

Giorgi (2009) saw intentionality as an important requirement of DPA, and therefore the inclusion criteria for this study can only consist of those who have been involved in a SI, as originally defined, and not other doctors who have vicariously witnessed a SI or other trauma, as that is outside of the experience being examined. Only qualified doctors who have full general medical Council (GMC) registration and have been involved in a SI were invited to take part in the research.

3.7.4 Exclusion Criteria

Doctors who have had or were receiving psychological therapy were excluded, as therapy might have influenced their perceptions of their experiences. Doctors who had not been involved in a SI were also excluded.

3.7.5 Sample Size

There is no definitive recommendation for sample size for qualitative analysis generally, or for DPA specifically. Giorgi (2009) suggested three participants would suffice, as it is the quality of the data the participants give, rather than the number of people in the sample that is paramount. Creswell, (1998) suggested 5-25 participants for a phenomenological study. As it is a university ethical requirement to provide a range, I decided that I would seek 6-12 participants. This was based upon the recommendations above for participant numbers and the outcome of discussions with my supervisor which took into account the sensitivity of the study topic. Eight participants were initially recruited. However, it came to light during analysis that the incident one of the participants described in interview, did not quite fit the inclusion criteria. Upon consultation with the university ethics department, I excluded this participant's data. Thus, seven participants were included in this study.

3.7.6 Recruitment

I initially sourced participants through word of mouth via my contacts with various doctors and then by snowballing, through participant recommendations to their colleagues, who passed my contact information to them. I received eight communications of interest and my initial response to them was via telephone. Once I had confirmed that they appeared to meet the study inclusion criteria, I emailed the study details to them (see appendix A p. 161-165). I then followed-up the participants, after three weeks, to answer any additional questions, to ascertain if they had read the participant information sheet and to see if they still wanted to take part in the research. I then sent a consent form prior to interview, which I went through with them before they signed it in order to confirm their consent prior to commencing the interview.

3.7.7 Participants

Seven participants were recruited in total. In order to protect participant confidentiality, each participant was given a pseudonym and any potentially identifiable information in the transcripts was changed. All participants confirmed that they were qualified senior doctors. The doctors had been registered with the GMC between 15 and 36 years (see participant demographic information in Table 1).

3.8 Pilot Interview

The pilot interview was carried out with an NHS healthcare employee. They were not a doctor but had been involved in a minor clinical incident that had occurred in their hospital department. This was because the topic of research relates to experiences of possible trauma. As such, I thought it would be unethical to interview a doctor involved in a SI and not make full use of the data acquired. The pilot was conducted to explore the interview schedule and to identify any possible problems with the questions. This included checking the sequencing of the questions, the phrasing and their clarity. As a result of the pilot participant’s feedback, some additional prompts were added such as, “can you tell me more about that?”

3.9 Data Collection and Processing

3.9.1 Interviews

Face to face, in-depth, semi-structured interviews were undertaken (see appendix A p. 160). The interviews lasted between 30 and 50 minutes and were recorded using a digital voice recorder. Consent was sought in writing for audio tape recordings to be taken of all the interviews. These recordings were transferred to a password protected file on the researcher’s computer. All of the interview audio recordings were transcribed verbatim, pseudonyms were added to the transcripts and any potentially identifiable data was changed. Confidentiality was further ensured by locking the anonymised printed paper transcripts and signed consent forms in a secure cabinet. The names and identities of the participants were kept by the researcher in a separate password protected computer file.

3.9.2 Procedure

The interviews were conducted at non-NHS venues, chosen by the doctors; these included hotel rooms and the doctor’s own homes. The necessary privacy of the venues was ensured in order to protect confidentially. Times were arranged at the doctors’ convenience. Prior to the interviews commencing, the researcher reiterated information about the study, including the participants’ right to withdraw and how confidentiality of the recordings and their transcriptions would be maintained. Participants were invited to ask any questions before signing the consent form and their demographic information was recorded by the researcher. At the end of the interview, participants were given a debrief letter (see appendix A p. 166) that included signposting information to relevant psychological support organisations, such as the BMJ support service.

3.10 Ethical Considerations

The researcher abided by the core principles of ethical research, as outlined by the British Psychological Society (BPS), Code of Human Research Ethics (2014) and the University of East London Code of Practice for Research Ethics (2015) as well as the Standards of Conduct, Performance and Ethics by the Health and Care Professions Council (2019).

Ethical approval was obtained for this study from the Research Ethics Committee of the University of East London (see appendix A p. 172/178/202). Each participant was given an invitation letter, which included details about the researcher, a description of the research, information about how the data would be kept confidential and details about the right to withdraw as well as the researcher's and their supervisor's contact details (see appendix A p161).

Each participant was asked to sign a consent form to confirm that they had read the study information sheet (see appendix A 164). Because an unreported SI could be judged a criminal offence, in order to cover the potential disclosure of a criminal office during the interviews, the participant information sheet included a requirement that doctors should have followed NHS policy in relation to reporting SIs. As the participant doctors were not undergoing NHS treatment for any psychological impact they reported and the interviews were not taking place on NHS premises, it was not necessary to seek NHS ethics approval (see appendix A p. 167-171).

Throughout the interviews, I was alert to any indication that participants were experiencing distress from recounting their experiences. The majority of my participants did indeed express distress at times during their interviews. When this happened, I checked to see if they wanted to continue with the interview. I used

Rogers' (1957) core counselling conditions of empathy, congruence and unconditional positive regard to communicate my support to them and to help them feel comfortable and unjudged. I allowed them to continue in their own time. Each participant chose to continue, citing the importance of the research to their discipline and their drive to contribute to it.

3.11 Reflexivity

Reflexivity is used in order to mitigate any deleterious impact the researcher's own deeply rooted judgements, assumptions and views might have upon their research (Carpenter 2008). It requires the researcher to be critically aware of their own inner mental processes (Morrow, 2005). In DPA there is less emphasis on reflexivity than in other qualitative research (Willig, 2013). As previously discussed, this is because there is a belief that a researcher can bracket or put into abeyance their own assumptions (Giorgi, 2009). However, as a counselling psychologist, I have developed an inquisitive and reflective approach, as this is a core skill requirement within the discipline (BPS, 2019). DPA is widely used in nursing research, a profession that also has a rigorous tradition of reflexive practice. Hamill and Sinclair (2010) suggested that in order to meet the needs of both reflexivity and bracketing a reflective journal can be used. Therefore, I kept a reflexive journal throughout the research journey following Gearing's (2004) reflexive bracketing typology which instructs the researcher to adopt a conscious, self-awareness of the bracketing process (see appendix F p. 290).

3.12 Analysis

In accordance with the DPA principles the participants' recorded narratives were transcribed verbatim. It is this text that becomes the raw data that is used throughout the DPA method (Broome, 2013). The analysis followed Giorgi’s (2017) descriptive phenomenological five step method of data analysis. This was an update on Giorgi’s (2009) four step model in that, unlike the earlier model, it has the act of assuming the psychological attitude explicitly included as the second step, because of its importance to the analysis. Giorgi (2017) recommended this especially for novice researchers, who he felt needed this to be explicitly stated. As this was my first experience of DPA, I decided to follow Giorgi’s (2017) advice. Below is the description of each of the steps undertaken in this analysis.

3.12.1 Step 1: Read the Transcript

Giorgi (2017) states that, “in order to do a proper analysis one has to know how the described lived experience ends”, (p 186). Therefore, the first step involves reading transcripts from the participants interviews, thoroughly. Unlike in previous iterations (Giorgi, 2009), Giorgi (2017) states that reading the descriptions can be undertaken by the researcher in their “normal, natural attitude” (p 186).

3.12.2 Step 2: Assume the phenomenological psychological attitude

In DPA, as in phenomenological philosophy, the everyday understanding that we have of the world is referred to as the natural attitude (Husserl 1900/1970; Giorgi 2009). It is within the natural attitude that we use our assumptions from our personal historical, cultural and past experiences and assumed knowledge to navigate within our “lived world”. In Giorgi’s (2017) description for DPA, the researcher is required to put aside their own natural attitude and adopt the “attitude of the phenomenological psychological reduction” (p. 186) in order to view data from a fresh unbiased perspective. This is how Giorgi (2009) stated bracketing or the epoché should be approached within his method.

The notion of bracketing derives from Husserl's (1900/1970) epoché in which any historical knowledge, preconceptions or theory the researcher may have in relation to the phenomenon under study is put aside. This enables the researcher to "see" the essence or fundamental structure of the phenomena from within the data and without concern for validity or existence. The researcher does not judge the veracity of the participants' descriptions, but instead accepts them as they are given (Giorgi, 2009; Giorgi, 2017; Broome, 2013). The researcher is therefore aligned with the notion of being "back to the things themselves". In this way, the intentionality towards an object in the description is never questioned but is included in the analysis by virtue of it being within the participants' consciousness.

3.12.3 Step 3: Determination of Meaning Units

Giorgi (1985), in describing the process of identifying meaning units, referred to landmarks or flow changes in the data. James (1912/1996) used the analogy of how a bird's journey might be marked by where it perches, rather than the distance it flies. There is still no analysis of the data in this step, the meaning units are simply noted. The purpose of the step is to enable the transformation of the data, as it makes the data more manageable rather than for any scientific purposes. I also re-expressed the meaning units into the third person, whilst staying true to the descriptions provided by the participants. Giorgi (2009) stated that this facilitates the researcher in remaining within the phenomenological psychological reduction during this process, by limiting any empathetic responses from them.

3.12.4 Step 4: Transformation of Participants' Natural Attitude Expressions into Phenomenologically Psychologically Sensitive Expressions.

Imaginative variation, within the psychological perspective, is employed on each of the meaning units. This eidetic analysis serves to reveal the invariant characteristics of the phenomenon being explored. That is, the meaning units are imaginatively examined, changed, varied and altered, in order to determine which qualities within them are essential and which are not, with the latter being deemed as outside of the phenomenological psychological structure being examined (Husserl 1900/1970; Giorgi, 2009, Giorgi, 2017). The meaning units are then transformed into psychologically expressed forms, without adding or subtracting any essential psychological meanings that were not already provided in the data (Giorgi, 2009, 137; Giorgi, 2017, p187). Thus, what is created are “psychological formations of the essential meanings of each meaning unit” (Broome, 2013). Still within the phenomenological psychological attitude, the researcher refrains from positing about or interpreting the transformations; they remain descriptions of the experiences of the participants, from their viewpoint. The essential meanings are considered to be constituents of the structure of the phenomenon.

3.12.5 Step 5: The Synthesis of the General Phenomenological Psychological Structure from the Psychological Constituents of the Experience

This, the final step consists of two tasks in order to complete the process of analysis of the data. Firstly, still enlisting imaginative variation, the researcher begins to see convergent meanings within the transformed descriptions related to their general psychological constituencies (Broome, 2013). These constituencies are then put into nominal psychological categories (Giorgi & Giorgi, 2003). The constituents are the essential parts of the phenomenon of interest and are interdependent of each other. The structure of the phenomenon is made up of all the essential constituents; in the absence of even one of them, the structure would collapse. However, not all of the constituents are useful. These are constituents that have variations; that is, they are not evident across the majority of the participants' experiences (Giorgi, 2009) and therefore are irrelevant to the phenomenon being explored. Through this exhaustive process, the essential constituents of the phenomenon can now be integrated into a single structure (Giorgi, 2009; Giorgi, 2017).

The next task, in the process of step 5, is to synthesize the constituents into the general psychological structure or phenomenon. This is a nomothetic not an idiographic outcome; the phenomenon rather than the participants is the focus of the analysis (Giorgi, 2009; Giorgi, 2017).

3.13. This Research

Thus, the method used for this research was as follows: I read all of the transcripts from start to finish. I assumed the attitude of the phenomenological psychological reduction at this point, bracketing any assumptions I might have had about the phenomenon that was under inquiry. I re-read the participants' transcripts carefully, with the purpose of parsing the data from each participant at certain locations within their descriptions, where I identified psychologically sensitive meaning changes. In order to differentiate them, I marked them with a forward slash (/) at the point where one meaning unit ended and the next began (see appendix C p. 204). I returned to the delineated meaning units and re-read them again. I carefully studied each meaning unit individually and considered how to highlight, "the psychological dimensions of experience" within them (Giorgi, 2009, p. 131). I transformed each participant's meaning units into phenomenologically psychologically sensitive expressions. In order to achieve this, I employed imaginative variation to draw out the eidetic nature of the data (Giorgi, 2009). The participants provided the descriptions of their experiences of being involved in a SI within the natural attitude, with everyday expressions and perceptions from their worldview included. Giorgi (2009) contends that embedded in these accounts are the contextualised meanings of the phenomenon which may not have been clearly articulated or may not be fully within the awareness of the participants He emphasised that they will not be on the surface of the descriptions, waiting to be found. Therefore, it is the researcher’s task to seek and clarify these implicit meanings and render them explicit. What is being sought are the invariant meanings that will ultimately, collectively, provide the essential structure of the second victim phenomenon. Thus, a sense of the whole is always in mind. Still using imaginative variation, I transformed the meaning units into constituents where there were convergent meanings, related to their psychological consistencies. I then synthesised the constituents into the general psychological second victim phenomenology structure. Next I will detail the findings of the research using this method.

CHAPTER 4

ANALYSIS

4.1 Overview

This chapter presents an in-depth analysis of the essential psychological constituents identified within the participants' transcripts. This will be followed by the general psychological phenomenological structure of the second victim phenomenon, created through the synthesisation of the identified constituents.

Pseudonyms were used throughout for the participants and any other people they referred to, to ensure anonymity and confidentiality. Each essential psychologically sensitive constituent's title provides a description of its psychological meaning, in order to uphold the DPA ethos that the focus throughout the study remains upon the experiences of the participants, as given (Broome, 2011). The analysis was conducted following Giorgi (2012), as set out in the previous chapter. The general psychological phenomenological structure of the second victim phenomenon is presented after the analysis of the constituents. Because the general psychological phenomenological structure is an overall more generalisable finding, derived from the descriptions and following Giorgi (2012), the second victims who the phenomenon describes will be collectively referred to as P.

Despite the safeguards of the psychological reduction, bracketing and the third-person transformation of the transcripts which have been used to support the researcher in remaining faithful to the participants' accounts, it remains that another researcher might express the meaning of the descriptions differently. Georgi (2009, p. 201) said of DPA, "…there will always be a one-to-many relationship between the intuited meaning and the words used to articulate it …an identical meaning can be expressed in multiple ways".

4.2 Identifying, Naming and Describing the Constituents of the Lived Experience of Doctor’s Involved in a SI

The constituents revealed in this analysis are the essential psychological aspects of the transformed meaning units (Giorgi, 2017). Nine constituents were found to be eidetically invariant (Giorgi, 2017) within the lived experience of doctors involved in a SI. Table 2 below gives a list of these constituents.

An analysis of each constituent is provided, along with examples of the participants’ descriptions that contributed to the constituents. The participants are referred to by thei pseudonyms used throughout this study, to signify their individual responses. Ellipses were used to condense the text in order to ensure a concise presentation, whilst still preserving what the participants said in their everyday language. In order to provide the prevalence of participants’ contributions to the constituents, the use of “all participants” refers to all seven of the doctors who participated, “most participants” refers to five or six of the doctors and “half of the participants” refers to four of the doctors. For this study, none of the constituents had less than four participants contributing to them.

Table 2: Constituents of the Lived Experience of Doctors who have been Involved in a SI

1	The unfolding of events leading up to the SI
2	The awakening awareness of the error
3	Searching the debris of a serious incident for answers using the retrospectoscope
4	The professional existential dread of being involved in a SI
5	Letting down those who trusted me with their lives
6	“You’ve got to hold it together”

7	The experience of helpful and unhelpful others
8	The psychological impact on the participants’ future practice
9	Psychological support: potentially an option if it had been available

4.2.1 Constituent 1: The unfolding of events leading up to the SI

Piaget’s (1986) observed that making an error is rarely a single event but a series of events; as such, she proposed that one becomes wrong. This constituent reveals how the participants have no awareness of the error they were about to make. The decisions and actions they were making at this point have unwittingly placed them on the path to error, when they will abruptly be transformed into a new state of “being irreparably wrong” (Paget, 1988 p77). This is something they will not understand until they have the benefit of hindsight. Most of the participants’ descriptions of their SIs included detailed descriptions of the events that led to the moment of error. Their accounts describe a worldview of normality and confidence in themselves and that they understood what was happening to their patients. Indeed, half of the participants had made preliminary diagnoses, reinforcing their understanding that they were in control of the situation. For example:

Julie’s SI happened in the midst of a flu epidemic, so that when she phoned her patient’s wife she was reassured by the description of symptoms given by her:

> *“I was rung by his wife who said that he had a high fever and flu like symptoms, and so I gave the normal service that you would for flu type symptoms”* (Julie, line 106 p. 31).

Laura, again, was reassured by the patient’s father who told her his daughter had previously been seen by another doctor:

> *"So, she is still having back pain and the painkillers weren't working…there wasn't any other neurology symptoms or anything to make me feel I need to go out now".* (Laura, line 43 p. 43)

George had attended a home visit for his patient the night before his SI and in response to his preliminary diagnosis followed a treatment protocol set out for that condition, as he explained,

> *"I thought she'd probably got a urinary tract infection and, in those days, we carried starter packs of antibiotics, I gave her the starter pack, gave her a prescription, left her that and I said okay, you know, let's see how things roll".* (George, line 79 p. 4)

All of the participants described themselves as being unaware that the sequence of events that would eventually lead to a serious error had already commenced. Pamela recalled that before her SI,

> *"we'd laughed and joked that here I was, you know, six hundred weeks pregnant, it felt like, my tummy was out there, doing their caesarean section so we were kind of doing a bit of a laugh and joke about the two things being so close".* (Pamela, line 73 p. 66)

Even when in a highly stressful environment, the participants described that they perceived themselves, just before the SI, as doctors confident in their expertise and in their ability to do their work regardless of the pressure:

> *"I've got a busy list I'm going to have to – we're going to be running late this afternoon, so people in the theatre aren't happy about that, so its compounded factors, last patient comes in. I say phone the surgeon from the*

> *afternoon and tell him we've got patients on the bed at 1 o'clock. I'm sure we'd be finished by 2 o'clock".* (Sophie, line 62 p. 101)

Summary of constituent 1

For most of the doctors, their experience of being involved in a SI commenced at the time period just prior to their SI occurring. Most of them described the unfolding of the events that led up to the SI as relevant and important. This was an invariant element of the structure of the phenomenon of the second victim because it demonstrates that the participants' worldview of themselves – that they were competent doctors who saved lives – was at this time intact. By disclosing this period of time, they were providing a description of their inner selves before their place in their worldview was shattered by the sudden awareness that a SI had occurred.

4.2.2 Constituent 2: The awakening awareness of the error.

This second constituent explores the doctors' experiences of the moment they realised that they had made a serious error and the impact it had upon them in the immediate aftermath. The realisation happened at different times for each doctor, for some in the immediacy of the error and, for others, after some time had passed. Nonetheless, all of the doctors described the moment when they realised they had become irreparably wrong and unable to make good their error, in shocked and emotional terms. At the moment of error there is a sense of startlement and uncertainty of what to do. For example, when George described the moment he realised how dangerously sick his patient was:

> *"…I was sitting there thinking I'm missing something here and then I went in and thought, right, yeah you know, blue, open the curtains and she was still blue. Oh God, what's going on here?... I'm thinking, oh Christ"* (line 94 p. 4)

Also, Laura, who had earlier formed the opinion that her patient did not have any worrying symptoms from a phone call she had had earlier with her patient's father, described her growing anxiety as she approached her patient's home:

> *"…but when I got there, there was a crowd of people outside the door and two ambulances* (Laura, line 50 p. 44) *...When I got in, the dad was on the landing and I... already, my heart was pounding… she passed away... sort of soon after my arrival..*(Laura, line 53 p. 44)

From the lived experiences described by the participants, there is a felt sense of no warning before a SI occurs. Thus, it is a sudden jarring of realisation. Furthermore, the participants shared a sense of shock and disbelief at the situation which became the felt emotion for them; they were taken by surprise by the error which leaves a void that disarms them, so they do not know what to do:

> *"…something that appeared to be relatively straightforward suddenly exploding into a catastrophe…".* (George, line 140 p. 6*) …I'm sitting there going, oh, you know, where did this come from?"* (George, line 119 p. 5)
>
> *"I was called for back pain. I certainly wasn't expecting her to be dead."* (Laura, line 65 p. 44)
>
> *"I was just stunned and I didn't know what to do in the moment."* (Heather, line 27 p. 17).

The participants' recall of their SI was remarkably detailed. Some of the participants even remembered details about the time or weather on the day their SIs commenced. For instance:

> *"It was a Tuesday afternoon and it was raining"* (Julie, line 95 p. 30)

"*The day was a sunny July Thursday"* (George, line 74 p. 3)

"I had a call mid-afternoon so it was at 3 or 4 o'clock". (Laura, line 38 p. 43)

It should be noted that the participants, as seasoned clinicians, were recalling incidents that had happened, in some instances, twenty or more years ago and yet their descriptions were readily recalled, in-depth and intricate. Not once did the participants say that these were memories viewed from a distance, vague or safely remote from their emotions. The descriptions were given as if they were recollections of a recent event.

Summary of constituent 2

The second constituent revealed the invariant experiences of the participants of the moment of realisation that they were involved in a SI. They describe a rapid transition from a sense of belief and confidence in their own judgement as doctors, to confusion, disorientation and despair. All participants described their SIs in wretched tones; all but one wept. It seems that not only does the moment of realisation involve becoming aware of the SI, but also the irreparable finality of the nature of it. As the participants described their SIs, the clarity of their memories of their SIs was striking, it was as if they were recent recollections of recent events. The transcripts contain very detailed accounts of the errors they made, some of which, I felt, were too graphic to include here in the main body of work, due to the public accessibility of thesis reports. What was clear was how the experiences of the SIs had stayed within the participants' memories for the rest of their careers. Once the participants were aware of their SI, they could do nothing other than seek answers. This is explored in the next constituent.

4.2.3 Constituent 3: Searching the debris of the SI for answers, using the retrospectoscope.

The “retrospectoscope” in the constituent title was taken from Heather’s description of seeking answers to what had taken place. It is a term frequently used in the medical profession to reflect the benefit of hindsight. In the aftermath of their SIs all of the participants sought an understanding of what had happened:

> *“and it was only afterwards, when things had happened that I went and thought, well, I’ve got to find some answers here, just find out what happened.”* (George, line 208 p. 8).

However, most of the participants also described that exploring what had taken place evoked thoughts of how they would have done things differently. In seeking answers, they not only ruminated upon the SI, but also upon what might have been:

> *“Me just wanting to rewind and do it right and you can’t”.* (“Sophie, line119 p. 104)
>
> and
>
> *“…wish they could wind the clock back and do it again.”* (Julie, line 300 p. 38)
>
> and
>
> “*maybe if I could go back in time and do something slightly different”* (Pamela, line 268 p. 73).

For Heather, looking for answers was described within the frame of the SI investigation process, which was initiated immediately upon her return to work:

> *“…in the…immediate aftermath, I was expected to complete a detailed report. What happened, why it happened, who was involved, naming names,*

> *absolute detail that was reliving it and it meant that it took such a long time to do because memories kept coming back and reliving conversations, and reviewing those conversations, and remembering those conversations, but seeing them through the lens of the retrospectoscope that would I have done the same thing knowing now what I know? Would I have said that? Is that what caused that? Could I have done that differently? So second guessing yourself constantly."* (Heather, line 47 p. 18)

Heather was required to recall as much detail as possible about her SI for the investigation in order to discover what happened but, for her, this involved repeatedly reliving it, placing it on a continuous psychogenic loop that she reviewed and added to, so that the loop spun in ever increasing circles and memories crowded her mind. Heather remarked that whilst this process provided insight into what happened it also created a vociferous inner voice to accompany her memories. The act of second guessing and self-criticism in hindsight that Heather describes is one that was reported by most of the participants. For example, Laura stated that:

> "*I think the overriding thing was oh my goodness, should I have come sooner… could I have changed...could I have prevented that?"* (Laura, line 75 p. 45)

Whilst she still simultaneously tried, *"holding it all together and trying to think of rational thoughts"* (line 81 p. 45) and find out what had taken place, not only for herself but also so that she could feel informed enough to explain it to the patient's father:

> *"trying to explain to him what had happened, trying to gain more history to be able to explain better to him."* (Laura, line 82 p. 45).

Simon also pondered about how his SI happened and also, how much he might be:

> *"directly responsible for it."* (Simon, line 85 p. 84).

Simon believed that, as a consultant physician, he is ultimately responsible for his patients, and that includes if they are involved in a SI, whether caused by human error or systematic factors. It is from this perspective that Simon explored what happened to cause his SI:

> *"…the guiding thing is still there, if somebody's been affected which is not a good thing, but then you want to see how much you are directly responsible for that. So, in some ways, as consultants we are, because then the patient until the patient leaves the hospital, you know, the ultimate responsibilities is with me for my patient, but I would like to see, is it because of the action that I did or didn't do?"* (Simon, line 84 p. 84).

The certainty and trust in their own knowledge and judgement the participants had described and outlined in constituent one, were gone, in the moments after the SI. In their place was overwhelming anxiety, that they were neither prepared for nor equipped to psychologically deal with. For instance:

> *"I felt the anxiety rise up in me. I felt as if I was trembling and I felt quite sick, I suppose, you know, feelings of anxiety."* (Laura, line 79 p. 45).

And for Sophie:

> "*I would describe it as an overwhelming feeling of anxiety. Yeah, so you're anxious with all of those sort of heart-pumping".* (Sophie, line 119 p. 104).

Summary of constituent 3

Looking back at the series of events that led to the SI provided the doctors with the answers they sought. However, this exploration also provoked a strong desire to turn back time and change their actions to prevent the SI from ever happening, followed swiftly by self-recrimination and self-doubt, not just about the series of decisions and actions they made that led to the SI, but deeper, philosophical doubts that were at the core of their identities as doctors. This formed the bases for constituent 4.

4.2.4 Constituent 4: The professional existential dread of being involved in a SI.

All but one of the participants' patients died as a result of the SI. The one who survived had such a close encounter with danger that it was treated in the same way as if they had died in what, in medical terms, is called a 'Never Event'. As described in constituent 3, the immediate time period after the SI was taken up with rumination and this process seemed to shake the participants' sense of identity as doctors. What followed were descriptions from most of the participants about how their thoughts turned inward. They describe how the eroding of their identities as doctors left them with a felt sense that they had failed in a duty not only to the patients, as described above in constituent 3, but also to themselves:

> *"…it was terrible, it was - there are points that I nearly thought I can't do this, I can't live with this kind of guilt. It was horrendous* (Julie, line 123 p. 31) *…it seemed to go to the very heart of what I was supposed to do as a doctor, it was supposed to be the very thing that I prided myself on, that I would be there and would make a good diagnosis and would help, and it seem to erode that very core of me.* (Julie, line 138 p. 32).

Julie's questioning of her ability further undermined her self-identity as a doctor and as a person. The guilt of her error was hard for her to live with, but so was the loss of her sense of pride. The very essence of who she believed herself to be was eroded; she no longer knew herself.

Again, for Sophie, what was meaningful for her in being a doctor had been impaired by her SI, to such an extent that her self-esteem and her sense of competence were undermined:

> *"How could this happen to me? how could I let this happen to me? That felt…the disappointment – it's a huge blow to your self-esteem or your – how you think of yourself as a competent clinician. So, it's a huge blow I would say to your self-esteem and quite an emotional blow to you in that way".* (Sophie, line 281 p. 111)

Pamela stated that she predominately experienced guilt, after discovering that her surgical intervention caused a fatal injury to a baby. However, implicit in her description is that she felt responsible for the death of the baby. This was regardless of the coroner absolving her of any blame. In her own mind, she had killed the baby:

> *"…and then as I became aware that they thought that it was because of a forceps injury then all I really had from that moment onwards was guilt. They did decide that it was one of those things but, it still was one of those things that I did". (Pamela, line 75 p. 65) … "I killed the baby, which I had [participant has tears falling from their eyes]." (Pamela, line 119 p. 67).*

The existential dread described by the participants above can be found in most of the doctors' accounts. Not only did they include a profound loss of trust in themselves, but also a questioning as to whether they could continue in their profession. Heather states that she felt that she could no longer be the provider of solutions and that this had impacted the equilibrium she felt between herself and her patients:

> *"And as a doctor, yes, a lot of it is a solution provider and that's what patients want, and not being able to do that and not being able to provide that, and feeling inadequate, and just thinking, "this is, this is too much, too hard, and I don't know how to reset the balance."* (Heather, line 118 p. 20)

George also, in the shock of his SI, felt the full impact of his patient's death and wanted to escape it. His implicit meaning is that, had someone else been looking out for his patient, she might not have died. In the aftermath, he also felt the weight of responsibility upon him:

> *"I just felt like giving up medicine because you just thought like oh my god, you know, someone's died on my watch".* (George, line 225 p. 9)

The belief that they should give up medicine was evident in most of the participants' accounts. Both Julie and Pamela were convinced that, so profound was the impact of their error, it was only their circumstances that kept them practicing medicine:

> *"I think probably, I mean I think it was around the time* that *Richard [participant's husband] was doing research as well, so - and it was when interest rates were like, 19%, I think if it hadn't been, I'd have given up, but we needed the money for the mortgage"* (Julie, line 236 p. 36)
>
> *"I think the only reason I stayed in medicine is because I was all alone. I think had I actually had something else I could do at that time I would have left".* (Pamela, line 225 p. 71)

Summary of Constituent 4

The impact of the self-recrimination described in the previous constituent left the participants bereft of faith and trust in themselves as doctors. Their self-identity as doctors, which they indicated was integral to their sense of competence and pride, was wounded. They lost sight of themselves as doctors. They could no longer see within themselves the expertise and qualities they believed were required to be a good doctor. Their instinct, driven by the pain of their own emotions, was to leave medicine At that point it was hard to imagine being confident enough to continue. There is a deep sense of responsibility for the death of their patients. They had failed in their duty to themselves. Also, they had a sense of failure of duty to their patients. This will be discussed in the following constituent.

4.2.5 Constituent 5: Letting down those who trusted me with their lives

The participants' descriptions of their inner turmoil and the damage to their self-identity, was accompanied by the perception that they had let down their patients and this had implications for the way they saw themselves. In the interview question used to help the participants feel comfortable, "tell me how you came to be a doctor", most of them spoke about the position of trust they perceived they held. For instance:

> "*…and often you then feel a bit humbled by the trust they put in you and similarly, you want to make sure you don't abuse that trust and let them down*". (George, line 56 p. 3)

And Julie explained:

> *"I think over time what you realise is this, is massive or both responsibility and privilege of being - of people opening their lives to you…that people will bring it and they will open their hearts and completely trust you, that I think is probably unlike - there are few other professions like that".* (Julie, line 23 p. 27)

The doctors believed that the trust they were given by their patients afforded great privilege, but that it also came with great responsibly. Understanding this helps to illuminate how the implicit psychological meaning of their narrative is that they were trusted and that they betrayed that trust and let their patients and the patients' families down.

Laura's perception of letting down her patient and their family, with trust as the implicit meaning, was almost too much for her to bear:

> *"oh my gosh, what have I done, what haven't I done… I've let these people down. How am I going to live with that? How am I going to recover from that"?* (Laura, line 429 p. 60)

This is echoed in Julie's description. She speaks of guilt and shame, but also fear, indicating the great responsibility she felt for her error:

> *"I can't kind of almost describe how awful it felt, it was a mixture of guilt and fear and shame that I've not done what I should've done."* (Julie, line 138 p. 32).

Simon provided further clarity. He explained that there are two experiential aspects of not upholding the trust they had been granted; there is the trust of the patient and then there is the trust of the family:

> *"you see, regret is actually augmented when you meet the family, and you have to actually explain that there are circumstances and there's—that there could have been a different scenario when their loved one is alive".* (Simon, line 202 p. 88)

The prospect of telling the patient's family that his error was the cause of the death of their loved one exacerbated Simons sense of regret. Implicit in that narrative is that, if it hadn't been for him, their loved one might still be alive.

Conclusion Constituent 5

The betrayal of trust in this constituent is illuminated by the participants' earlier references to trust. This becomes implicit in their narrative about letting people down. The notion of letting the patients and their families down highlighted the burden of trust that was perceived by the participants. The participants could hardly endure the knowledge of the betrayal that their SI represented. There was no escape, they were answerable to their patients' families and they had to bear witness to the impact their error had upon them whilst quelling the pressure of their own remorse. Shame and regret merged with the blend of emotions already being experienced and another casualty of the SI is the participants' confidence in their own trustworthiness.

4.2.6 Constituent 6: "You've got to hold it together"

It became clear that the emotional experiences described by the participants were not openly expressed at the time and, in some cases, remained essentially hidden.

Furthermore, there is a sense of a façade, an attempt to appear as if they were not in mental turmoil, whilst actually experiencing a wide range of emotions, including grief for the loss of their patient. For instance: Simon spoke about how he mentally compartmentalised any sense of emotion, because he discovered that:

> *"you start realising that that will affect you and then you can't judge, you can't make a clinical judgement"* (Simon, line 235 p. 89).

Simon continued:

> *"One is clinical judgement and two, if I didn't compartmentalise I'm going to be sort of spreading the guilt, spreading the regret to a wider group which I don't need to, I don't need to carry my problems home".* (Simon, line 245 p. 90)

Thus, Simon compartmentalised his emotions because in his life-world it maintained his professional effectiveness and also shielded his colleagues and family, from the emotional experience of the SI.

Heather, in explaining that she had lost empathy for other patients, echoed Simon's analogy of putting away emotions, for her in a box, although she had difficulty with keeping them securely harnessed:

> *"It's exhausting, and I think it, there's a risk of it cracking in that you - it's almost like you put it in a box and you push it to one side, and it's held there, it's still there erm, and the lid is as closed as you could get it but it's still there, and you focus on the other box that's the day to day, but this box is threatening to open all the time, and sometimes it does, and sometimes a bit seeps out and you've got to readjust and put the lid back on the box again, and that constant navigation and constant erm balancing is, is exhausting, and you don't get it right because, you know it does spill out, it does...it*

> *becomes all-consuming and you can't think about anything else."* (Heather, line 144: p. 1)

Laura provides insight into this constituent. The implicit meaning of her comment below is that to show emotion is unprofessional:

> *"I had a whole volley of emotions there" [participant had tears falling from her eyes].* (Laura, line 60 p. 44) *…but at the same time, I knew you had to be professional. You've got to hold it all together"* (Laura, line 80 p. 45)

Implicit in Laura's quote is that "holding it all together" is a learned response to challenging emotions that the medical profession encourages and that is perhaps related to the culture in healthcare. Therefore, this concealment is undertaken for the benefit of others.

Pamela also implied that the concealment of emotions was a necessary response that doctors are expected to adopt in order to be seen to maintain professionalism:

> *"Well, right from the start really, as a doctor is that you don't ever show that you have any feelings or emotions, so you just put on your I'm fine face".* (Pamela, line 162 p. 69)

Julie was entirely unable to articulate what had happened. The place in her psyche where she held the experience of the SI was inaccessible to her:

> *"I couldn't talk about it, I didn't talk about it at all for 10 years"* (Julie, line 180 p. 33)

And even during the interview Julie struggled:

> *"I think I can talk about it now without crying, that's pretty major, it still makes me upset inside, and so how long is that ago, it was - I think it was 1990, 30*

> *years, isn't it, and I think that's the thing, it never goes away. I think I said I can do it without crying"* [participant has tears falling from her eyes] (Julie, line 221 p. 35).

Summary constituent 6

There appears to be no outlet for the layers of emotion described by the participants, instead they are concealed behind professional façades or personal psychological defences. The purpose of this response seems to be to hide their emotions from their colleagues, perhaps for fear of being judged by them. Yet, they did not report that they received a direct instruction to hold it together, but indicated that they perceived it was expected of them and that to express their emotions would not be professional. Perhaps it was that same expectation that led the participants to discuss the clinical aspects of their SIs with other doctors, rather than to discuss the psychological impact with anyone else; this is discussed next.

4.2.7 Constituent 7: The experience of helpful and unhelpful others

All of the participants described how they went to discuss their SIs with other doctors, particularly with senior clinicians. It became evident that most of the participants sought help through vindication or validation for the clinical decisions they had made. Others expressed a need for help with the experience of being involved in a SI. George spoke to a number of colleagues, including the hospital clinicians and surgeons who had subsequently worked on his patient:

> *"…his take on it was—I don't know how you guys do it, how do you spot something like this in the community. So, very supportive about the challenge in recognising something at the start of a journey. The gyne [gynaecology] consultant, I worked for him for six months and he just said, "Look, these*

> *things happen. You know, you didn't miss something, you acted on it."* (George, line 192 p. 8)

Heather had mixed experiences from the clinicians around her. For instance, in the immediate aftermath of discovering her patient had taken their own life, Heather was provided with personal help, care and attention:

> *"I sort of was ushered upstairs, given a cup of tea, and sort of blugh and out it all poured and one of the partners then came upstairs and told me...listened, supported, talked to me about it and then said, "You need to go home… they recognised I wasn't safe to drive and so the practise manager in fact drove me home and handed me over, to my husband and we went back later to pick the car up".* (Heather, line 33 p. 17)

However, upon the commencement of the investigation into the SI, she discovered a different attitude from others:

> *"you think you have...the way you think you think you're going to get support then is not forthcoming, you realise that that could happen anywhere, the people you think you should be able to go to, you can't".* (Heather, line 237 p. 25)
>
> *"…but their perception of a support meeting and my perception of a support meeting are very different and what actually happened was an interrogation".* (Heather, line 72 p. 18)
>
> *"It felt absolutely like I was being cross-examined in the dark".* (Heather, line 77 p. 18)

The mixed responses Heather received from colleagues were damaging for her and had a long-term impact on her professional relationships:

> *“I am more cautious, I’m certainly more cautious with who I form work relationships with, I’m more suspicious I suppose with work relationships because I think erm, “Yeah, we can all be friendly on a superficial level,” but you think you have...the way you think you think you’re going to get support then is not forthcoming, you realise that that could happen anywhere, the people you think you should be able to go to, you can’t. Okay, that’s just a little bit of self-preservation here, let’s just hold back and keep relationships at a distance, don’t get too close”.* (Heather, line 234 p. 24)

This example from Heather is an indication of the potential impact if a doctor involved in a SI has sought help, clinical or otherwise, but is rejected. Heather now psychologically defends herself in protective self-isolation and will not allow any meaningful relationships with her colleagues to develop.

Julie, on the other hand, found comfort in her senior colleague’s assistance. The fact that he went to court with her acted as an affirmation of his trust in her clinical judgement, helping her towards repairing her self-esteem:

> *“I think the senior partner was - he knew and he was there with me and he was there in the hearing with me, and him being kind of believing in me I think was a big help…, and I think that - just somebody knowing, just somebody who understands actually what it might feel like helps”.* (Julie, line 318 p. 39)

Sophie was also helped by her colleagues normalising experiencing a never event in their work:

> *"A lot of people are saying oh, never events, we don't worry about those anymore. I've had so many never events and people – you're not the only person in the world who has ever had a never event".* (Sophie, line 320 p. 112)

Laura also spoke to her senior colleague immediately after she left her patient's home and explained that it was the act of disclosing that helped:

> "*But when I came out of the house, I sat in the car and it...I really felt deflated. I felt as if all the energy had been sucked out of me and I just wanted to fall but I knew I couldn't and what I did was I phoned my senior partner who'd been with me that day working in the afternoon and just told him. I wasn't expecting him to advise or do anything. But I just wanted to tell him. I chose him because of the confidentiality... ...and there was a... And I can't remember what he did or said, nothing particular, but it was a release for me... ...and that did help. To disclose".* (Laura, line 165 p. 49)

Laura went on to describe the compulsion she felt that resulted in her phoning her colleague:

> *"part of me just wanted to say I've just had this awful experience and I just need to let it out because it was building up inside me".* (Laura, line 252 p. 52)

The notion of relief at disclosure was evident in Laura's account. It seems that it is not necessarily reassurance that is required but a sense of releasing the experience to an other, so that she was not alone in the knowledge that harm had come to her patient.

Summary of constituent 7

Most of the participants sought help from other doctors after their SIs. However, others also sought personal help as well. With their sense of self-identity depleted, the participants were unable to self-comfort and, because of this necessity, they turned to others seeking solace, vindication and validation. Those they turned to understood what it was to be a doctor and therefore they were best placed to reflect back to them what they had lost in themselves. Most turned to senior, more experienced colleagues and, where support was given, the participants indicated that they could begin the journey towards restoring their trust in their abilities. However, despite the support received, they were changed and this will be explored in constituent 8.

4.2.8 Constituent 8: The psychological impact on participants' future practice

Despite receiving support from their colleagues, most of the participants said that they changed as a result of the experience of being involved in a SI. Some of the changes were profound. For instance, many of them avoided aspects of their work that reminded them of their SI, while others became hypervigilant in their care for their patients. Many of the participants reported thinking through various scenarios that might happen in their treatment of their future patients, in order to anticipate where things might go wrong.

The positioning of avoiding in order to defend against situations similar to when the participant's SIs occurred is apparent across the descriptions that contributed to this constituent. For example, George said that:

> *"it took me a very long time to shake it off and I suppose, I become quite defensive for a while. I managed to laugh it off in a way of saying, "Right, well…" you know, I said, "You know, on Friday the 13th, I'm not going to do any clinical work on Friday the 13th, so I teach or I take the day off."* (George, line 165 p. 7)

Where George could not carry out clinical work on Friday 13th, the date his SI occurred, Julie could no longer make patient calls from home, the task she undertook that contributed to her SI:

> *"… what I didn't do was calls from home on the phone, I couldn't do it no more, and they were really good [Julie's colleagues], they were really good, and they enabled me to do that, it was just too – I mean I don't think I ever got over it as a clinician".* (Julie, line 255 p. 36)

Another behaviour change evident in most of the participants' clinical work was paying particular attention to their practice in areas similar to where their SI occurred. Laura described a careful approach when dealing with house calls, after her SI:

> *"but what I will do is say, first of all, clarify whether or not they need to be seen now and whether or not they need...happy for me to call later, whether or not things have changed and I look for red flags and safety netting".* (Laura, line 208 p. 50)

Laura continued that:

> *"In how I approached people when they were requesting house calls, that was main thing. Change in practice and I mean, I usually look at the past medical history but just to reinforce that as well, yeah. Yeah, yeah, definitely. I'm...I*

> *just make sure that it's okay to leave the patient for a few hours"*. (Laura, line 373 p. 58)

Julie described becoming ardent in her work:

> *"I mean certainly I became much more you know…fervently, I visited every single person, every single patient I recalled I would visit".* (Julie, line 255 p. 36)

Many of the participants described how they would meticulously mentally work through all of the permutations they could think of in relation to what might go wrong in a given clinical scenario. For example:

> *"I am a much more obsessive person doing obstetrics…I often get laughed at because I have everything, all the potential possibilities mapped out now in my head for anything I'm going to do which is sort of automatic now, I think okay that's what's supposed to happen it could happen and if that happened I could do this that and the others so I think it makes you perhaps more anxiously looking at where your intervene in whatever it is that you are thinking of…"* (Pamela, line 217 p. 71)

And also, George stated that:

> *"it teaches you never to assume anything. Always have that sort of degree of scepticism, and certainly a degree of clinical awareness where you turn around and say, okay, I'm working on that thing but there are other things I need to keep my mind open about. I think, I mean, how did it come; I wouldn't say I was more cautious but never underestimate the sort of ability of a condition to take you by surprise.".* (George, line 341 p. 13)

Summary of constituent 8

All of the participants reported that they changed their professional behaviour after their SI. They indicated that caution and vigilance or having a heightened level of clinical awareness followed rapidly after the SI, contrasting with the confidence and self-assurance they experienced prior to the SI. The implicit meaning within their descriptions was that this change has stayed with the doctors throughout their careers.

4.2.9 Constituent 9: Psychological support: not considered, but would have been if offered as part of the process

None of the participants were offered psychological support. Although most noted that their SIs had happened some time ago, some also mentioned that little has changed. Most of them reported that they were expected to *"carry on"* (George, line 244, p. 36) and indeed did carry on, despite the psychological impact they experienced as analysed above, *"I had to carry on*" (Julie, line 244 p. 36). Many of the participants indicated that they felt that an opportunity had been lost and that they had to hide their true feelings. Pamela reported that she and her colleagues had to:

> "*put on our game face at work*" (Pamela, line 169 p. 69).

Julie described how she could have benefited from having psychological support:

> *"…the combination of factors that go like a perfect storm to create* [a SI] *and there's a much greater understanding of that, and that the damage that you do by not managing these things well, then you know, in terms of resources, in terms of psychological damage, I think there's much greater recognition, but that hasn't led to there being support put in at the point that you need it,*

> *because I think the timing is critical, and if I'd had it at the time, really good help and support, that would've been- I mean it would've changed my life and certainly life as a doctor, and just to be able to talk about it would've been helpful, but I didn't ever think it could, I mean it wouldn't have crossed my mind that that could've been simply because you weren't- it wasn't talked about really."* (Julie, line 355 p. 40)

Julie indicated that an opportunity to change her life and ease her psychological pain as a person and as a doctor was lost. She described a narrow period of time during which, she believed, psychological help would be effective. However, in her opinion, at the time of her SI, her profession would not even have considered it as an option. Julie stated that, although there is now more awareness about the potential benefits of psychological support in the medical profession, nothing has changed and psychological support is still not automatically provided. It was apparent that in the past, seeking psychological support, for those involved in a SI, was not the norm and that there is little to suggest that it has a presence in the management of individuals involved in serious incidents now.

Pamela also spoke about what was considered normal practice at the time of her SI and the lack of availability of psychological support:

> "*I think if it had been the norm to have it offered, I would have definitely done it…I think had it been seen as a normal approach towards how people*". (Pamela, line 365 p. 77).

She continued:

> *"it would be something that I probably would have definitely done and I think if it was readily available".* (Pamela, line 383 p. 78).

Laura said that she took behavioural cues from her colleagues:

> *"where you see your other colleagues and they're quite resilient and you see them having to pick themselves up and carry on and you yourself have experienced things and pick yourself up and carry on".* (Laura, line 293 p. 54)

These accounts indicate that the participants, at the time of their SIs, were influenced by the normative expectations of their organisations and peers and that they prioritised them over their own needs.

Sophie's description of what receiving psychological support would have meant to her indicated that it would have been an indulgence: a professionally unaffordable opulence. Instead, she expressed an awareness of psychologically defending herself by focusing on her team:

> *"I think it might be helpful for the team to do it actually. Yes. How about me? It would've felt eh very supportive and almost a luxury, but I think it would've been nice to have. So, I suppose, part of my defence mechanisms were looking after the other people over there [the surgical team] and that it would've been good to talk as a team because you're almost like committed a crime, gets separated off, so that people take different statements from different people".* (Sophie, line 379 p. 115)

In the latter part of this quote from Sophie, she is referring to the very rare practice of isolating the personnel and environment involved in a SI, in order to wait for confirmation that a criminal offence has not been committed.

Unlike the other participants, Heather did seek psychological support after her SI, but gave a scathing account of her experience:

> *"So how do you choose somebody? I mean, if I tell you what it looks like to look at a counselling website, I hate to say it, but you have head and shoulder shots that for some counsellors I think they're trying to apply for film roles with cleavage and full makeup and coy poses so you can discount those straight away, and then once you got past the visual you start looking at, "I'm a specialist of integrative counselling," and, "I'm a Gestalt counsellor," and I'm a blah, blah, blah, blah. I'm a doctor and I don't know what that means, how the public works through all of that rubbish and then how do you know if you've got a good one? 'I've got CBE, X, Y, Z, RBT'. And the reality is there are people out there who are mental health trained who've done a half a day on CBT and set themselves up as CBT counsellors so immediately I, you know, registered with, I know what that means too, it means you pay your 50 quid to have your name on the list, so how do you choose? So, it was the practical of, 'Oh, am I going to choose on the basis of geography"?* (Heather, line 187 p. 23)

Heather's account of seeking psychological support from external sources paints a picture of her growing confusion and mistrust of the counselling profession. Resentful, Heather felt there was no option but to deal with any mental health impact from her SI alone:

> *"I don't need somebody to listen to me, I need – I will get through this, it was, it was what was I going to say? This happened, I feel terrible. I know I'll feel better. What are you going to tell me that I don't already know?"* (Heather, line 198 p. 23)

Summary of Constituent 9

None of the participants had psychological support after their SIs. Instead, they followed the norm, taking their cues from their colleagues and carried on with their work, seemingly as usual. The participants seemed nonplussed at being asked and implied that it was not something that doctors would do. However, it seemed that had someone offered psychological support, they would have considered it, but it was very clear that, on the whole, they would not have independently sought it. The one participant who indicated that they had looked for a counsellor, gave a whithering account of what that experience was like for her. Nonetheless, the indication from most of the participants was that their experience of being involved in a SI was difficult as they continued to experience the psychological impact from their SIs, and many still do.

The nine constituents above were synthesised to form the general psychological phenomenological structure, as presented below.

4.3 The General Psychological Phenomenological Structure

The error that P is about to make commences beyond their conscious awareness. The events leading to the error are already in motion and are entwined in the phenomenon as the last moments unfold of P’s worldview of themselves as being assured, confident of their own judgement and in control of their patient’s health condition. This worldview is shattered in the instant the error occurs, as the realisation of it and how irreparably final it is awakens within P’s awareness. P has been ambushed by the SI. P is startled, shocked and stunned into an inability to know what to do next. P seeks an understanding of what happened, of how the error has occurred but in doing so they find a deep sense of regret and a yearning for the time to be returned to them so they can do something differently that would avoid the SI. P turns inward upon themself and admonishes the decisions they made that led to the SI and, whilst there, they question who they are as doctors and the core beliefs of their worldview; their self-identity is eroded by the creeping doubt in their ability and the notion that they might be a bad doctor. P experiences a profound loss of trust in themself and considers that they are not good enough to be in the medical profession. This is compounded by the sense that they have also violated a fiduciary duty with their patient and their families, that they have breached the crucial compatibility of their positioning as the wounded and the healer. P conceals the myriad emotions they experience, in compartments and boxes that can be exhausting to keep contained, whilst outwardly they project their professional persona. P turns to their senior colleagues, seeking help, vindication and validation in a bid to repair their damaged sense of self. Despite the comfort P receives, they cannot return to who they were before the SI, they are changed. P becomes more vigilant and fervent in their practice. P avoids scenarios that remind them of the SI and meticulously imagines where things might go wrong in similar encounters with a patient. P will not proactively seek psychological support. Instead, they observe how their colleagues carry on, regardless of how difficult it is and feel obliged to conform to this professional bravado. However, P would have seen a psychologist, had the service been brought to them. P is too occupied with suppressing their emotions and carrying on, to seek a psychological service themselves. Years later, P will be able to bring to mind the SI with razor sharp clarity in an instant, even remembering dates and times. This will be accompanied by a re-living of the SI experience; they will be plunged into the moment of error as if it had just happened and they will weep again.

4.4 Conclusion

This chapter has presented the analysis of the constituents that were transformed from the meaning units, identified in the descriptions of doctors who have been involved in a SI. The constituents, once brought together to form the general psychological phenomenological structure, enabled the story of the second victim phenomenon to be told coherently, whilst remaining faithful to that which was given (Broome 2011). What follows this chapter includes a discussion of these findings in relation to the current literature and the proposed direction for future research. I will finish this analysis, with a quote, as it was given:

> “I think it was 1990, 30 years, isn’t it, and I think that’s the thing, it never goes away. I think I said I can do it without crying” [participant has tears falling from her eyes] (Julie, line 221 p. 35).

CHAPTER 5

DISCUSSION

5.1 Overview

This Chapter commences with a summary of the findings from the study's analysis.. Each constituent involved in the synthesis of the general phenomenological psychological structure will then be reflected upon, in relation to the existing literature. The contribution to counselling psychology and the general psychology community will also be explored. The strengths and limitations of the study will be considered. A critical evaluation of the study will be presented along with recommendations for further studies and this will be followed by my conclusions.

5.2 Summary of findings

The participants clearly experienced significant psychological distress when they became aware that they had made a serious error. Although they were keen to unravel what had happened clinically to cause the SI, they denied their emotional responses by supressing them. The participants reported a felt sense of change within themselves which endured throughout their careers, describing being hypervigilant and avoidant of circumstances similar to those of their SIs. However, they did not recognise these behavioural changes as being manifestations of their psychic pain, and so they did not consider seeking psychological support. The longevity of the emotional upheaval they experienced is exemplified by their ease of access and clarity of the recall of the incidents, as well as the striking emotional responses during their interviews. What follows is an exploration of the findings, in relation to current literature which is undertaken by discussing each constituent separately. The implications of the findings in the field of second victim research are also discussed.

5.3 Contextualising the main findings in the literature

The general second victim phenomenological psychological structure is the framework of the second victim phenomenon. This framework was constructed by synthesising the nine constituents that were revealed in the previous chapter, which comprised: 1) The unfolding of events leading up to the SI; 2) The awakening awareness of the error; 3) Searching the debris of the SI for answers using the retrospectoscope; 4) The professional existential dread of being involved in a SI: 5) Letting down those who trusted me with their lives: 6) “You’ve got to hold it all together”; 7) The experience of helpful and unhelpful others 8) The psychological impact on participants’ future practice; 9) Psychological support: potentially an option if it had been available.

5.3.1 The unfolding of events towards the SI: Paget, in order to explain the nature of mistakes, used the analogy of, “taking the wrong path” (1988, p. 45). She explains the usefulness of thinking of mistakes in this way, because it describes the unfolding of a path to error, rather than the error being a single event. She posited that awareness of the mistake can only come retrospectively; a mistake is at the end of a, “sequence of acts” (p. 45).

The participants described the confidence they had in their own expertise and ability before the error and the surety they had that they were in control of the situation and their patients’ wellbeing. For instance, George had no awareness of what was to come, when he prescribed antibiotics for his patient, who in reality required emergency surgery (George, line 79 p. 4). Pamela expressed that she was so unaware of what was to come, she was able to joke with her patient (Pamela, line 73 p. 66). The moments before a doctor makes a serious error are not focused upon in the second victim literature. However, this constituent and the next illustrate the unique advantage DPA offers, in enabling me to demonstrate the second victims' frame of mind in those moments. I was able to draw on research that investigated how doctors' confidence in their expertise is developed, to explain the participants' emotional attitudes before their SIs.

The positioning of doctors with their patients is documented in research into doctors' self-identity. (DelVecchio-Good & Good, 2005; Lingard, Garwood et al., 2003). These researchers posited that doctors develop their medical identities while training. They become medically socialised in an all-encompassing and enduring way, which influences both the professional aspects of their lives and their innermost personal values (Cicourel, 1999). Other researchers have suggested that doctors' identities are maintained through dialogical processes, for instance, in their communication with each other using medical terminology and undertaking inter-relational professional activities such as ward rounds and case conferences (Apker & Eggly, 2004; Good & Good, 2000; Lingard et al., 2003). Mulcahy (1999) posited that doctors adopt an omnipotent persona for their own benefit as much as their patients', because they have to be confident enough to make rapid decisions using medicine's inherently uncertain knowledge base. Thus, immediately before making their errors, the participants' self-image as doctors is one of infallibility.

These findings are important because they reveal that medical culture and communication are influential in forming doctors' self-identities, starting from medical school (Good et al., 2005; Lingard et al., 2003). Medical school could therefore be the optimal time to introduce psychoeducation into the second victim phenomenon to the medical profession, with the aim of reducing the psychological impact of any SIs the students might be involved in during their future careers. This preventative recommendation would be a new approach towards combatting the impact of SIs on second victims.

5.3.2 The awakening of awareness of the error: The participants lingered at the point of realisation. By doing so they revealed a detailed, rich, visceral account of a rapid transition from a sense of self-surety to becoming cognisant of both the occurrence of the error and its finality. Their descriptions of the experiences of becoming aware indicated that they did not know what to do and this seemed to disarm them of their certainty, (George, line 140 p. 6). This echoes Dekker's (2012) suggestion that second victims can experience helplessness, which he warned could lead to PTSD. The literature does document the shock that second victims experience at the point of realisation of their error (e.g., Burlison et al., 2017; Dekker, 2013; Scott et al., 2009). Scott refers to, "a moment of time that seems to suspend and slow down to become an unforgettable memory" (2016, p. 6) and "the moment of impact" (2016, p. 6).

Shaw (2007) discussed the psychoanalytic perspectives of what he called "the acute traumatic moment" for wounded war veterans. He defined this as "…the sudden conscious awareness of intense and devastating feelings of helplessness to cope before the fear of injury and death" (p. 24). This theory of psychic trauma could potentially also be relevant to second victims. Shaw (2007) posited that three psychic processes are overwhelmed in the acute traumatic moment; narcissistic defences that protect the idealised self, the illusion of safety and the mechanisms of denial. These processes are intertwined in that the idealised self is protected within narcissistic defences, which includes the "cherished" illusion of safety (p. 34). In the traumatic moment, a tear is rent in the illusion, which damages the powers of denial and the individual becomes aware that there is an incongruity between the idealised self and reality; helplessness is then experienced.

This is reminiscent of the participants' accounts of their moment of error. For instance, Heather's account of being stunned and not knowing what to do (Heather, line 27 p. 17), seemed to reflect this helplessness as the illusion of safety was ripped away. She haemorrhaged belief in her abilities as a doctor and, in that moment, could not reconcile them with the suicide of her patient; instead, Heather had to face a very different reality. George also described a moment of awareness of catastrophe, that rendered him unable to identify what happened (George, line 119 p. 5), despite having formulated what he thought was a robust diagnosis. The awakening of awareness is indeed a rude one for the second victim.

Berceli (2009), suggested that the experience of trauma can be followed by memories that fail to be integrated in the normal way. This produces unprocessed stimuli that can be easily triggered by certain related cues, so the sufferer re-experiences the trauma as if it is happening again. This is reflected in the participants' behaviour. For instance, George still avoids working on Friday the 13th (George, line 167 p. 7) and Julie stopped calling patients from home (Julie, line 260 p. 36). Berceli (2009) posited that it is these unprocessed stimuli that cause nightmares and flashbacks. Berceli, (2009) also claimed that this can continue for years after the trauma event.

The participants' descriptions are strongly suggestive that they experienced trauma from the moment of realisation of their SI. Furthermore, according to Shaw's (2007) research, it is also the moment that their self-identities as doctors were damaged.

This may be why immediate psychological interventions, such as debriefing, may be counterproductive and possibly damaging (NICE, 2018). Instead, NICE (2018) recommends a period of monitoring following trauma to establish whether symptoms persist, suggesting PTSD. Unable to do anything else, the participants sought to understand what had happened. The participants' quest for answers created the content of the third constituent.

5.3.3 Searching the debris of the SI for answers, using the retrospectascope: Scott et al. (2009) in their research regarding their proposed natural trajectory of recovery, placed seeking answers as their first stage, coupled with chaos and external and internal turmoil (p. 326). They reported that their participants enquired what had happened in their adverse events, but, unlike in this study, there was no mention of them discovering that, in seeking answers, they developed an intense, regretful longing to turn back time, nor that their participants expressed a sense of responsibility (e.g., Laura, line 75 p. 45). A potential reason for this difference is that Scott et al.'s (2009) participants may not have all been involved in SIs. They did not record the types of events and incidents their participants had experienced but their participants' most prevalent psychosocial symptom was "frustration" (p. 328), which was a symptom not reported in the literature related to Wu's (2000) original definition of second victims. Scott et al. (2016) later identified that health care workers generally wanted to change a negative outcome generated by an adverse event.

Snook (2000) came close to the essence of the participants' accounts given in this study during his investigation into how, in post-war Iraq, a fighter pilot came to shoot down two allied helicopters carrying United Nations peacekeepers. He quoted the fighter pilot as saying, "I wish to God I could go back and correct my link in this chain

— my actions which contributed to this disaster" (p205). An intense sense of culpability is, according to Dekker (2012), so unique to second victims, they can be identified by it. Dekker (2012) stated that feeling responsible for their SI is what provokes the "potent" (p. 88) feelings of guilt, trauma and depression. Such was the expression of responsibility by the participants in this study, they could be defined as second victims by Dekker's (2012) criteria. This has significant implications, as it indicates that screening of those involved in SIs for a high sense of responsibility could identify those most in need of psychological support.

The psychological impact described by this study's participants was extensive and became the fourth constituent to be included in the general structure of the second victim.

5.3.4 The professional existential dread of being involved in a SI: Paget (1988), referring to her participants' narrative, stated that it was difficult to find a word that truly expressed what it was like for them when they became aware of the "stark finality" of their errors (p. 77). She eventually chose the word "anguish", because she said it is the experience of, "agonising physical or mental pain, torment or torture" (p. 77). From the first accounts of doctors who published articles about their medical errors, there have been descriptions of them experiencing profound psychological anguish (e.g., Christensen et al., 1992; Hilfiker, 1984; Lazare, 1987; Newman, 1996). The participants in this study were no different. Most of them described long periods of self-recrimination, self-doubt, emotional pain, guilt, helplessness, anxiety, depression and an altered sense of self. These descriptions are said to be indicative of psychological trauma and potentially PTSD (e.g., Dekker, 2012; Fullerton et al., 2005; Kessler et al., 1995; Scaer, 2014). Furthermore, the fact that all of this study's participants' SIs caused serious harm or death or were a never event renders them susceptible to PTSD and other high levels of psychological distress (NICE, 2018; Waterman et al. 2007).

The self-recrimination further diminished the participants' already damaged self-identity. Julie told of feeling that her error went to the heart of her expectations of herself as a doctor and seemed to erode her “very core” (Julie, line 138, p. 32). Sophie also referred to her error changing how she thought about herself (Sophie, line 282, p. 111). This reinforces the argument for screening for second victims, as proposed in the previous constituent, so they can receive appropriate psychological interventions in a more timely fashion.

5.3.5 Letting down those who trusted me with their lives: This constituent identified how the participants had, as an aspect of their awareness, a sense of the trust placed in them by their patients before their SI and a loss of this when the SI occurred. As doctors, they had responsibility for their patients' wellbeing, which brought with it a burden of trust which was both a privilege and liability to them. They perceived their SIs as letting the patients and their families down, and therefore being a violation of that trust. They described experiencing guilt, shame and regret. These emotions were amplified by the necessity to meet their patients' family and telling them what had happened.

This adds to Scott et al.'s (2009) findings in the trajectory of recovery they postulate for second victims. As discussed in the literature review, Scott et al. (2010) reported that their participants referred to trust only in relation to their colleagues. They were concerned that other clinicians would no longer trust their work and that they would be viewed as a weakness in their team. The participants in this study, on the whole, spoke of how their colleagues tried to help them. At no time did they say that they were concerned their colleagues had lost trust in them. Their focus, in regard to trust, was upon the patients and their families and how they had let them down. To my knowledge, this study is the first to discover that second victims' emotional responses to their SI include the awareness they have violated a fiduciary duty. They had let their patients and their families down; they had not lived up to their expectations and for that they were profoundly remorseful. This awareness is yet another aspect of the experiences of second victims that erodes their sense of confidence and their self-identities as doctors.

5.3.6 "You've got to hold it together": In this constituent, the participants described how they concealed their emotional responses to being involved in their SI in various ways. They compartmentalised them (Simon, line 245 p. 90), they put them in a box (Heather, line 144 p. 21), as professionals they held it all together, (Laura, line 80 p. 45). The participants referred to applying a mask or putting on a game face (Heather, line 96 p. 19; George, line 253 p. 10; Pamela, line 215, p. 71). The literature has documented the intense emotions experienced by second victims (e.g., Dearmin, 2020; Hilfiker, 1984, Wu, 2000) and the possible consequences of those emotions staying with them throughout their careers, should they be unable to share their experiences (Christensen et al., 1992; Newman, 1996).

Wastell (2002) researched the suppression of emotions in paramedics who are required, as part of their jobs, to stay calm and controlled in stressful situations. He found "striking" (p. 843) results indicating that suppressing emotions as a defence is maladaptive and is the largest predictor of stress and ongoing trauma-related symptoms. Wastell (2002) found a limit to his cohort's endurance of this maladaptive defence. He noted "physical and psychological harm" (p. 843) to his participants. Perhaps this is why second victims have been found to have higher levels of sickness absenteeism and prematurely leave the profession than doctors who have not been involved in a SI (Burlison, et al. (2016). It was evident that the psychological pain of the participants in this study was suppressed, and that it went on to create distance from others, including patients, prolonged their crisis and increased their symptoms. Research shows that this was potentially preventable. If second victims were helped to explore their emotions and to understand them it may reduce what could be seen as avoidance behaviour (Wu, 2000) and the long term risk of harm as described by Wastell (2002). Whilst the participants in this study concealed their emotions, in the next constituent they did want to talk about the clinical decisions they had made.

5.3.7 The experience of helpful and unhelpful others: The literature investigating the second victim phenomenon indicates that perceived barriers prevent participants from seeking psychological help (Brooks et al., 2017; Carpenter, 2014; Davidson et al., 2003; Spiers et al. 2017). The participants in this study did not bring up any perceived barriers to seeking psychological help but nevertheless, with one exception, did not seek any. Instead, with their emotions securely suppressed, they only sought help from colleagues and had varying degrees of success with doing that. They indicated that, in the first instance, they wanted vindication and validation for their clinical decisions. George went to a number of his hospital colleagues (line 134 p. 5) and others went to senior colleagues to discuss what had happened to cause their SIs. For instance, Laura described talking to her senior colleague as relieving a need to share what had happened (line 251 p. 52). Julie's senior colleague helped her to feel validated by attending her patient's coroner's hearing with her (line 319 p. 39). George's colleagues reassured him that he had done everything he clinically could have, given the circumstances, (line, 133 p. 5) and Sophie’s colleagues normalised her SI, reducing the impact of having been involved in a never event (line 184 p. 107).

Heather (line 72 p. 18) had a more mixed experience. Initially, her colleagues were attentive to her but, once the investigative process commenced, she found the experience punitive, dividing her colleagues and damaging their professional relationships. Harrison, et al. (2014) claim that doctors fear SI investigations and lack confidence in the reporting system. Heather’s experience provides insight into the impact that investigations can have on doctors; this is a potential area for further research.

Fox (1989) proposed that as well as individual identities, doctors have a “collective identity” that develops through their shared experiences from their earliest training and throughout their careers. Mizrahi (1986) went further to suggest that as part of this group identity, there is a certain protective collegiality between doctors, which they will be drawn to as a defensive response when feeling vulnerable. Perhaps what the participants in this study are describing, when they refer to turning to colleagues after their SI, are their attempts to restore their self-identities within the safety of the collective identity they hold as doctors. However, their conversations with their colleagues were generally not about the emotional impact of the SI but about the clinical details of what had happened.

This finding is significant for patient safety teams in the NHS. The role of patient safety managers in investigating SIs is central, but their focus is almost entirely upon establishing the facts. It is not unreasonable to suggest that it would be beneficial for them to be trained in the psychological impact of being involved in a SI as well as in specialist communication skills, as they are working with vulnerable individuals.

Although most of the doctors who sought support from their colleagues were positive about their experience, they went on to say that, despite this they felt changed and that they adjusted their professional behaviour in response. This is discussed in the next constituent.

5.3.8 The impact on participants' future practice: For most of the participants in this study, carrying on did not involve continuing as before. They stated that the experience of being involved in a SI changed them, some personally, most professionally. They reported that, in direct response to their SIs, they avoided situations that were similar to those of their SIs. This tactic may not be in the best interests of second victims as research has demonstrated that avoidant behaviour exacerbates PTSD (e.g., Pineles et al., 2011; Sripada et al., 2013). In addition, the participants described experiencing hypervigilance, sleep disturbances, helplessness, stress and disengagement with other patients, substance misuse, intrusive thoughts, depression and, in one case, post-natal depression, (this participant believed that there was a direct causal relationship between her SI and her post-natal depression). These symptoms have all been documented as being indicative of PTSD (e.g., Dekker, 2013; DSM-V, American Psychiatric Association, 2013; Fullerton et al., 2005; Kessler et al., 1995; NICE, 2018).

As previously stated, Bichescu, et al. (2005) posited that individuals who do not receive treatment for PTSD can still manifest symptoms years after the traumatic event. All of the participants reported changes in their practice that lasted throughout their careers, including changes resulting for the loss of the level of self-assurance they had enjoyed before their SI. Julie whose SI took place thirty years ago, said it never goes away (line 223 p 35). Although Pamela said that she feels it made her a better doctor (line 119 p67), her relationship with her daughter was irreparably damaged by her post-natal depression and she still pauses to try to predict every possible eventuality before she commences a caesarean section (the intervention during which her SI occurred). Scaer (2008) stated that even small changes in an individual's behaviour after a traumatic event are likely to be manifestations of PTSD.

Scaer (2014) reported that trauma sufferers feel a sense of loss of who they once were. He proposed that sometimes even years later, although time may have healed to some extent, most individuals with untreated traumatic experiences feel enduringly and irrevocably changed and that no amount of time or life experience restores their altered sense of self.

The participants' descriptions in this constituent concur with the above research and is indicative of PTSD. They all reported SIs that had taken place years ago and demonstrated how they were still suffering. According to the findings outlined here, this was unnecessary had the appropriate actions been taken at the time of their SIs.

5.3.9 Psychological support: Not considered but would have been if offered as part of the process: Despite the obvious psychological distress all of the participants experienced, none were offered psychological support.. They were nonplussed at the idea of therapy. As they were longitudinal deniers, this is unsurprising. The participants' descriptions indicated a lack of insight into both the extent of their psychological distress and the personal and professional costs they have paid which have persisted across the years. Most of the participants stated that seeking help from a psychologist or therapist would not have occurred to them. They indicated that it was not something that was done by doctors at the time of their SIs and, in their opinions, it was not likely to be thought of now either. The clinical culture in the NHS, they said, did not include room for psychological support, either then or now. The fact that this cohort indicated that seeking psychological help would not have occurred to them appears to be reflected in the currently proposed organisational models of support (e.g., Edress et al., 2016; Harrison et al., 2017; Nocera et al., 2017), in most of which it is unclear how a second victim manifesting symptoms indicative of PTSD would be assisted in receiving psychological support other than by informal signposting. Unusually, Scott et al.'s (2010) systemwide rapid response programme, that implements three tiers of support, does have a formal referral procedure to psychologists and counsellors. They mention a need for haste in referring tier three second victims, but it appears that second victims have to work their way through tier one and two before they can be recognised as needing that additional assistance.

It is unlikely that the organisational models of support referred to above, which were developed in North America, would be approved in the UK, because they include debriefing and peer support. Influential organisations such as NICE (2018) have recommended against the use of debriefing due to a lack of evidence for its efficacy and they have strongly advised that peer support should only be carried out by psychologists or other qualified therapists. The recommended treatment for PTSD is CBT and more recently, eye movement desensitization and reprocessing (EMDR) (DSM-V, American Psychiatric Association 2013; NICE, 2018). However, there are currently no plans to increase the availability of these treatments to address the specific needs of second victims in the NHS.

5.4 Summary of significant new findings

There were a number of unique findings in this study that will contribute to the literature and to developing support for second victims. As far as I am aware, this is the first study into the phenomenon that provided an account of the frame of mind the doctors were in immediately before their SIs. It showed that the participants had adopted defences during their training that supported their self-identity when treating patients, including being omniscient. In addition, because the participants provided such rich and in-depth descriptions of the process of going from a sense of omniscience to the realisation of the SI, it has brought into sharp relief the process of that transition.

The previous literature related to second victims has not explored how important doctors' self-identity is to their being able to perform exceptionally well as clinicians and how being involved in SIs can undermine that. It has not been previously suggested that this weakening of self-identity is linked to the trauma symptoms that second victims manifest. Furthermore, this study found that the second victims perceived that they have violated their patients' and their patients' families' trust, whereas the previous literature placed the focus of their concern on losing their colleagues' trust. This study corroborates Dekker's (2012) finding of second victims as originally defined by Wu (2000) experiencing a profound sense of responsibility. This provides an opportunity to develop a screening tool for early identification of those second victims who would most benefit from psychological interventions.

5.5 Clinical Implications

This study's findings have clinical implications for counselling psychologists and the wider psychological community. The finding that being involved in a SI can damage doctors' self-identity is important because there is strong evidence that doctors' self-identity provides defence mechanisms which are integral to their ability to perform optimally within a profession that has tragedy and death as common work experiences and still hold their nerve (Mulcahy, 1999; Shaw, 2007). An altered sense of self for doctors could undermine these defence mechanisms. The concept that this study's participants' self-identity was damaged by their SI, was upheld by their account of a felt sense of inner change. Another striking finding was the participants' reports of the range of emotions they felt. They reported feeling responsible for what happened and, they felt guilt, shame and remorse. They also reported suppressing these emotions which has previously been found to be detrimental to clinicians physical and mental health and wellbeing (Wastell, 2002)

The humanistic perspective that is at the heart of counselling psychology could provide an empathetic and safe space for second victims to explore the impact that the SI has had upon them and perhaps begin to understand the complexities of their experiences that they are struggling to conceal. The validation of the self, that is a core aim in counselling psychology, may help second victims to restore their damaged identity, and so improve their performance as doctors and therefore the safety of their patients. Therapeutic interventions that help second victims to reconnect with their emotions might help them and ultimately help the NHS to retain them as effective members of staff.

The participants described emotional turmoil, which is highly suggestive of PTSD (e.g., Dekker, 2012; Harrison et al., 2014; McLennon et al., 2015); this diagnosis is supported by the participants' subsequent behavioural changes, such as becoming hypervigilant and avoidant of circumstances similar to those of their SIs, which are also recognised features of PTSD (Berceli 2009; Scaer, 2014). These behavioural attempts to alleviate their suffering risk exacerbation of PTSD symptoms (e.g., Pineles et al., 2011; Sripada et al., 2013). The participants reported that these experiences had endured throughout their careers which has implications for all the patients they treated after their SIs, who may not have received optimal care. NICE (2018) have explicitly stated that only qualified specialists, such as counselling psychologists should administer treatment for PTSD (NICE, 2018).

Counselling psychologists and the wider psychological community should also aim to normalise doctors' experiences of being involved in SIs. Psychoeducation programmes could be developed in order to inform doctors of the second victim phenomenon and the options that are currently available to them. These could be delivered to qualified doctors, but also to medical students where the acquisition of medical socialisation begins. By educating them about how we might intervene and how it might help, we could enhance their experiences of being doctors if they are ever involved in a SI.

Currently there is no guidance for recognising doctors as second victims, nor protocols to follow to ensure they are offered psychological support. Although times are changing, it is important for psychologists and therapists to make concerted efforts to educate the medical profession about the psychological impact of being a second victim and the range of benefits we can provide. Considering the estimated number of second victims in our health service, these findings are indicative of a pressing need to develop sufficient capacity for therapeutic interventions to support them and to improve patient safety.

Since the introduction of the NHS Health and Well-being Improvement Framework (Department of Health, 2011), large NHS organisations have started to provide psychological support for staff through their occupational health services and. counselling psychologists could contribute to these services. Dissemination of the findings of this study at, for example, medical conferences provide additional opportunities to influence policy by raising awareness of the second victim phenomenon and its impact on staff wellbeing and patient safety, not just to clinicians but also to senior healthcare policy makers.

In summary, I hope that the insight gained from this study will enlighten the counselling psychology field and the wider psychology community and enable them to provide psychological support from an informed position. Importantly, I also hope that this study's findings serve to enlighten the medical community that if they are involved in a SI they are at risk of developing PTSD and should therefore seek appropriately qualified help.

5.6 Strengths and Limitations of this study

5.6.1 Strengths

This study has added to the second victim literature from a completely new perspective, that of the life-world of those who were experiencers of the phenomenon. It is the only study to use the second victims' descriptions of their experiences of being involved in a SI, as given. It has highlighted several areas where the participants' accounts have converged with previous findings of empirical research, thereby strengthening and refining the overall understanding of the second victim phenomenon by contributing a conceptual frame that epitomises the experiential structure of the second victim phenomenon.

The goal of DPA is to reveal the essential structure of the phenomenon under study, as given by the experiencer. DPA does not define phenomena in ways that can be quantifiably measurable, nor does it involve theorising or interpretation (Giorgi 2009). By adopting DPA I was able to access depths of enquiry that might be unattainable by quantitative approaches (Mason, 2002).

Another strength is that the rigour of the interview process was increased by undertaking a pilot interview. The pilot participant's feedback about their experience of their interview, enabled me to adjust my positioning away from being the trainee to being the enquiring researcher. Finlay (2009) highlighted the risk of novice researchers bringing their therapeutic selves into the research room. The reason why I followed Giorgi's revised five step model of DPA (2017), as opposed to his earlier four step model (Giorgi, 2009), was because maintaining a psychological attitude was easier to adhere to as the second step in the model, which in his original model, was presented as a general concept.

Overall, this study's strengths are that it revealed previously unknown insights into the second victim phenomenon. Not only is this worthwhile for providing these insights to the psychology community, but it also provides a mirror through which doctors might recognise their own reflections.

5.6.2 Limitations

Perhaps the predominate limitation is that the generalisability of the findings is limited because DPA is a contextualised process. For instance, the study findings may differ in another cohort, such as another clinical group, or they might be less applicable to clinicians practising in the private medical sector. I cannot currently claim any universal applicability beyond doctors involved in SIs, until my findings are explored further. Giorgi (2009) himself described DPA as an ideal platform for ongoing research into a phenomenon.

There was a relatively small sample size used in this research. However, Giorgi (2017) vigorously defends the use of small purposeful sampling on the basis that the interviews provide such rich and in-depth data, which is then arduously analysed. As

I had followed Giorgi (2017) throughout this research, I opted for a small sample of seven participants. Larger research cohorts could be within the remit of further research into the second victim.

A further limitation in the study could be that the participants were required to recall their SI from several years ago. There are some controversies surrounding recall bias in qualitative research generally (Hassan, 2005). However, Giorgi (2009) is clear that DPA is interested only in the participants' truth within their life-world and not necessarily the accuracy of their memories.

Finally, I was a completely novice DPA researcher and I felt trepidation at the prospect of using it. However, Giorgi's (2017) step by step guide helped enormously, not least step two, which helped me to keep within the psychological attitude but also to remain aware of my role in the epoch. I was aware of these limitations, so I undertook a pilot interview as outlined above which mitigated against any untoward implications for the study itself.

5.7 Validity

Ensuring validity in research is a means of staying within the perimeters of the research process as intended as well as maintaining quality and rigour throughout the study (Mason, 2003). Yardley (2000) proposed four general criteria by which validity in a qualitatively designed study can be measured, which were adhered to during this study.

The first criterion is sensitivity to context which refers to the researcher being sensitive to the impact of the interview process upon participants. My research topic took the participants back to a time in their life they found difficult to recount. I remained alert to their mood, offering breaks to them when they became emotional and I was non-judgemental and empathetic to their accounts. After the interviews, I stayed with each participant for a long period of time. I debriefed them, but also listened, as each of them spoke about their interview experiences. I only left when I felt that they were emotionally stable.

Yardley's (2000) second criterion is commitment and rigour. I have been committed to the topic of the second victim since my work in patient safety which spanned six years and from when I first became aware of the distress of clinicians who had been involved in SIs. I have followed the literature related to second victims since then. In order to ensure my competence in using the DPA method, I read Giorgi's (2009; 2017) published literature that gave in-depth instructions. I also read the works of other people who had previously used DPA in their research or provided additional advice (e.g., Broome, 2013; Englander, 2012). In relation to the data, I listened to the recordings I made of my participants interviews and transcribed them verbatim. For rigour and following Giorgi (2017), the entirety of all of the transcripts were included in the analysis. I followed Giorgi's (2017) five steps, exactly as described in the method section, with the aim of extracting the phenomenon from the transcripts by identifying the psychologically sensitive invariant essences of the participants' descriptions, in order to create the general psychological phenomenological second victim structure. The participants were chosen by strictly adhering to the inclusion and exclusion criteria; they were all qualified doctors, registered with the GMC, who had been involved in a SI. None of the SIs were considered to be criminal actions and, as such, legal involvement was not required. An area of Yardley's (2000) validity criteria I did not adhere to was in relation to homogeneity within the cohort, as this would have been inconsistent with Giorgi's (2017) methodology, which required that my participants had to be non-homogeneous.

Yardley’s (2000) third criterion relates to transparency and coherence. Yardley (2000) states that most qualitative researchers “construct a version of reality” (p. 222). However, in DPA the researcher remains faithful to the descriptions provided by the participants (Giorgi, 2017). I did not construct my findings via theory or interpretations (Giorgi, 2017). Nor did I “recreate a reality” (Yardley, 2000, p. 222). However, through the presentation of the transformation of the data into psychologically sensitive constituents, that were then synthesised into the general phenomenological psychological second victim structure, it is believed that the reader will recognise the narrative as meaningful to them and, as such, the quality of the prose will be evident (Yardley, 2000). This approach is reflected in my research question and is aligned with my ontological belief that reality exists outside of human consciousness and my phenomenological epistemological positioning in that each individual will potentially view that reality differently through the lens of their own idiosyncratic experiences.

In DPA, the transcripts are the raw data (Giorgi, 2017), I read the transcriptions a number of times before selecting meaning units which I indicated with bolding the last word of the meaning unit and a forward slash (see appendix C p. 203). This was done with the entire raw data (Giorgi, 2017). I then transformed the data into the psychologically sensitive constituents which I colour coded (see appendix D p. 216). As not all of the data were relevant to the phenomenon being studied, not all of the data were included in the colour coded process or onwards in the analysis. I strictly followed Giorgi’s (2009) instructions in terms of the data collection process. I maintained a psychological attitude throughout the analysis. Giorgi (2009) likened this to being a therapist, but without relying on theory or interpretation, thus I adopted a “naïve, pretheoretical” (Giorgi, 2009, p. 135) stance. Giorgi (2017) stated that to effectively utilise bracketing one must not allow the past to influence the researcher. In order to be aware of where my past might become influential, I wrote a reflective list about my experiences with second victims (see appendix G p. 291). My supervisor read and provided feedback on my analysis and I listened to my pilot study recording with the aim of identifying any gaps in bracketing.

Lastly, Yardley's (2000) fourth criterion is the research topic's impact and importance. Throughout this study, I checked its relevance to any emerging second victim research literature and NHS policy updates and other relevant publications.

5.8 Recommendations for Future Research

The life-world of second victims has not previously been explored from the subjective experiences of doctors who have been involved in a SI. Giorgi (2014) highlighted the potential for further enquiry once the life-world of a phenomenon has been revealed by DPA. He opined that it can be used as the starting point for all other elaborations or research into the phenomenon. This study has identified a number of potential areas for future research. These include research into implementing preventative measures such as psychoeducation for clinicians, patient safety managers and other staff in order to address the lack of understanding about the phenomenon among frontline staff. An example of this is stress inoculation which Meichenbaum (1977) adapted from the anger management programme and has been developed and applied by Novaco (1977) to people who were likely to encounter stressful events, with favourable results. Stress inoculation involves training individuals pre-emptively in CBT techniques, compassionate mind training and mindfulness meditation and has been shown to offer some protection against stress and trauma in a variety of personnel including in the armed forces and nursing (e.g., Jackson & Baity, 2019;

Lewis & Hourani, 2015). It would be interesting to explore whether the stress inoculation model could be used early in doctors' training to help them to cope with any SIs that they might be involved in during their future careers.

Screening tools for early identification of second victims could be studied, so that psychologists can be involved early in supporting them. An example of this would be to screen those involved in SIs for a deep sense of responsibility which this study has shown to be a feature of second victims, confirming the previous findings of Dekker (2012).

The general phenomenological psychological structure of the second victim phenomenon can be used to undertake interventional or theoretical research with more precision. For example, this study supported the link between second victims and trauma, but in addition revealed that potentially influential self-identity defences seem to be entwined within the trauma experience. This would benefit from being explored further.

This research has also confirmed that the trauma of a SI can stay with doctors throughout their careers and beyond and that they are changed by their experiences. Further research could be undertaken to test the effectiveness in second victims of the currently recommended treatments for PTSD such as CBT and EMDR (NICE, 2018), specifically with doctors who have been involved in SIs.

A growing number of clinicians other than doctors are taking increased responsibility for patient care. Nurses, allied health practitioners and clinical scientists can be trained as advanced practitioners, whose roles include prescribing medication and undertaking procedures. This gives them the potential to be involved in a SI (following Wu's 2000 definition) so this research could be repeated in these other professional groups. DPA could also be used to explore the lived experience of clinicians involved in other types of traumatic situations, such as those who have been providing frontline care for patients during the COVID-19 pandemic.

5.9 Conclusion

In conclusion, the findings of this research provide a unique insight into the lived experiences of second victims, as defined by Wu (2000). This included discoveries of aspects of being a second victim that had not previously been identified, thus revealing novel information about the second victim phenomenon. One striking example is the finding that trauma impacts doctors' self-identity and undermines their much-needed confidence in themselves. Another is that one of the reasons that they conceal their experiences of psychological distress caused by SIs is that they are unconsciously responding to the medical socialisation, that they first experienced as junior doctors and that was maintained throughout their careers. The study has also revealed that doctors have no clear understanding of what the second victim phenomenon is, nor awareness of the extent of the impact it can have. Finally, the study has shown that doctors would not seek psychological support because it is so far removed from their clinically normative lifeworld, that it simply would not occur to them. This does however seem to be changing. Since I completed my data collection, the medical profession has become more receptive to the idea that they can be psychologically adversely affected and that they may need to seek specialist help. This has sadly come about because of the COVID-19 pandemic (NHS Employers, 2020).

The majority of the other findings in this study supported previous empirical studies thereby strengthening most of those data. One possible exception was the finding that the participants in this study appeared to be more concerned about a loss of trust from their patients and their patients' families than from their peers, as has previously been suggested by Scott (2010).

By using DPA (Giorgi, 2017) the voices of the seven doctors who participated in this research are heard throughout the study process. As the analysis of the participants' descriptions of being second victims was undertaken from within the phenomenological perspective, they have not been blended into pathologizing or interpretating processes; they could be imagined as a choir of authentic voices. Those voices were chosen with care. There were many groups of clinicians that were excluded from recruitment at this time, including nurses, who have taken on more responsibilities for patient care since Wu (2000) first turned the spotlight onto doctors and the impact upon them when they are involved in SIs. However, I wanted to return to that beginning, at the inception of the concept of the second victim, because that was when doctors began to talk openly about being involved in SIs.

The essential meanings within the participants' descriptions were transformed into the language of psychology for the analytical process, but also to provides insight into the minds and experiences of second victims. I believe this knowledge will facilitate those in counselling psychology and the wider psychology community to attune to second victims from a humanistic positioning, which is what I believe they would most benefit from. I hope that the findings of this research will offer the opportunity to develop policies and guidance which enhance the availability of psychological support to second victims and its uptake by them in a timely way.

The general phenomenological psychological structure of the second victim phenomenon that was synthesised into existence in this study, gives substance to what has previously been referred to but has never been truly understood in all its complexities. The structure has widened the horizon for second victim research at a point where it might have been thought that everything that there was to know was known.

5.10 One further final thought

I sat with each of the participants after the interviews to debrief them. Each of them in turn reflected on their experiences of the interview. They had never spoken about their SIs before, other than for investigation purposes. They seemed unsurprised and almost expecting of the emotional upheaval they experienced during the interviews. It is hard to describe the atmosphere between myself and my participants during the interviews. Paget (1988) also often struggled to find words. One phrase that she chose because, “it is both vivid and precise” (p. 77) particularly resonates for me as it describes what I found so well - ‘bitter remorse’.

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APPENDIX

Appendix A: Ethics Forms

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply for ethical clearance from HRA (through IRIS) for research involving the NHS you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship

PLEASE NOTE that HRA approval for research involving NHS employees is not required when data collection will take place off NHS premises and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

If you are employed by the NHS and plan to recruit participants from the NHS Trust you work for, it please seek permission from an appropriate person at your place of work (and better to collect data off NHS premises).

PLEASE NOTE that the School Research Ethics Committee does not recommend BSc and MSc/MA students designing research that requires HRA approval for research involving the NHS as this can be a demanding and lengthy process.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2018)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website
https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16)
https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%20forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.
2. Type your name in the ‘student’s signature’ section (5.1).
3. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc**
4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. Your supervisor will then look over your application.
5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the ‘supervisor’s signature’ (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.
6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the participant invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.
- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. If you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice.

- DBS clearance is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Tim Lomas (Chair of the School Research Ethics Committee) at t.lomas@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 4 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another for the duration of your studies in order to conduct research with vulnerable populations.

Please read all guidance notes in blue carefully to avoid incorrect or insufficient applications

If yours is an online study using Qualtrics please see the example ethics application in the Ethics folder in the Psychology Noticeboard

SECTION 1. Your details

1. **Your name**: Catherine Barton-Sweeney

2. **Your supervisor's name**: Dr Stelios Gkouskos

3. **Title of your programme**: Professional Doctorate in Counselling Psychology

4. **Submission date for your BSc/MSc/MA research: August 2020**

5. **Please tick if your application includes a copy of a DBS certificate (see page 3)** ☐

6. **Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)** ☐

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk** ☐

8. **Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics** (See links on page 1) ☑

SECTION 2. About your research

9. What your proposed research is about:

Please be clear and detailed in outlining what your proposed research is about. Include the research question (i.e. what will your proposed investigate?)

Whilst it is acknowledged that patients and their family or carers are the primary concern when a serious clinical incident occurs, Professor Albert Wu, suggested that the doctors involved are also "wounded by the same errors" and, as such, are "second victims". In his article, Wu described the traumatising effect that being involved in a SI can have upon doctors. This led to research that examined the impact of the second victim phenomenon.

This research provided overwhelming evidence that being involved in a SI can undermine the psychological wellbeing of doctors to such an extent that some manifest persistent symptoms including those of post-traumatic stress disorder (PTSD).
In terms of recommendations for support for those involved in SIs, counselling has not been considered a priority and it is unclear why not.

One group thought to be particularly vulnerable is junior doctors because, although they are still in training and are therefore inexperienced, they are often put in positions of responsibility where there are high risks of errors which could harm their patients.

Therefore, It is proposed that this research will endeavour to explore what the experience of being involved in a SI is for junior doctors and what they think might be the barriers to seeking psychological help.

10.Design of the research:

Type of experimental design, variables, questionnaire, survey etc., as relevant to your research. If the research is qualitative what approach will be used and what will the data be?

This will be a qualitative research design, using a descriptive phenomenological approach.

The data will be audio-recorded and transcribed one to one semi-structured interviews.

10. Recruitment and participants (Your sample):

Proposed number of participants, method/s of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research.

It is proposed that 12 – 15 participants will be sought.

The participants will be recruited through email request, sent from their academic deanery.

The participants will be junior doctors in the first four years of post-graduate training who have been involved in at least one SI, these are the only specific characteristics being sought.

11. Measures, materials or equipment:

Give details about what will be used during the course of the research. For example: equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application.

Face to face participant led interviews will be undertaken and audio recorded using a tape recorder.

An interview schedule will be used (please see attached)

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / [✓ NA]

13. Outline the data collection procedure involved in your research:

Describe in detail what will be involved in data collection. For example, what will participants be asked to do, where, and for how long? If using online surveys will you be using Qualtrics? Detail what you will include in the Qualtrics page that you intend to make available to potential participants (see the example ethics application for a student study using Qualtrics in the Ethics folder of the Psychology Noticeboard).

Participants will be asked to attend face to face interviews and answer the research questions. The interviews will last no longer than two hours.
The venue for the interviews will be non-NHS – the deanery will help identify a venue once ethical approval has been confirmed

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

How will you fully inform your participants when inviting them to participate? Will the participant invitation letter be written in a style appropriate for children and young people, if necessary?

The participant invitation pro-forma will be used (please see attached).

All participants will be adults over the age of eighteen.

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Is the consent form written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians? How will you gain consent if your research is collecting data online (e.g. using Qualtrics)?

The consent pro-forma will be used (please see attached).

16. Engaging in deception, if relevant:

What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.

Participants will be told about the nature of the research. No information will be withheld from the participants at any time.

17. Right of withdrawal:

In this section, and in your participant invitation letter, make it clear to participants that ‘withdrawal’ will involve (1) participants being able to decide to not continue with participation in your research, and (2) the right to have the data they have supplied destroyed on request. You are asked to give participants a three-week window from the time they participate in your study to when they can withdraw their data. Make this clear in your participant invitation letter.

Note: If your study involves data collection through Qualtrics, it is essential that you ask participants to provide their own participant code on Qualtrics (e.g. two letters and two numbers) so that you will be able to identify them if they later want to withdraw their data.

The right of withdrawal, as stated above, will be made clear to participants in the invitation letter.

As recommended above, participants will be given a three-week window from the time they take part in the research to when they can withdraw.

18. Will the data be gathered anonymously?

This is where you will not know the names and contact details of your participants? In qualitative research that involves interviews, data is not collected anonymously because you will know the names and contact details of your participants.

YES / **NO**

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually data will be destroyed after a study is over but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? (suggested time is two years). It is advised that you destroy all names and contact details of participants at the end of your study regardless of how long will keep your data for. Make this clear in your participant invitation letter.

The names and contact details of participants will be kept in a password protected file on the researcher's personal computer for which access, is also password protected. Only the researcher will have access to the participants names and contact details. Real names and any identifying references will be omitted from the reporting of data and transcripts etc.

Once the study is completed and the researcher has passed their viva voce, all names and contact details of participants will be destroyed. The transcript of the anonymised interviews and analysis will be stored, under password protection as described above, because the researcher intends to develop their research for publication. This remaining data will be destroyed after six-years, from the end of the study or the required timeframe of a publishing journal, if different.

20. Will participants be paid or reimbursed?

This is not necessary, but payment/reimbursement must be in the form of redeemable vouchers and not cash. Please note that the School cannot fund participant payment.

YES / **NO**

If YES, why is payment/reimbursement necessary and how much will the vouchers be

worth?

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required? YES / [✓ NO]
Please see Page 1 of this application for important information and link

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

The participants are NHS employees and they will be recruited via their academic deaneries. The interviews will not take place in NHS premises. The researcher enquired of the HRA if approval was required and was directed towards an electronic questionnaire, which when completed indicated approval was not required (please see attached).

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?
YES / NO/[✓ N/A]

22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

You need to attach written permission from external institutions/organisations/workplaces if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation.

Is permission from an external institution/organisation/workplace required? [✓ YES] / NO

If YES please give the name and address of the institution/organisation/workplace:

Health Education England Kent, Surrey and Sussex
4th Floor,
Stewart House
32 Russell Square
London
WC1B 5DN

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

YES / [✓ NO]

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks (can be physical, emotional or psychological)? How will the safety and well-being of participants be ensured? Will contact details of an appropriate support organisation or agency be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?

The support organisation or agency that you refer participants to in your debrief letter should be appropriate. That is, is there a more appropriate support organisation than the Samaritans, for example (i.e. anxiety, mental health, young people telephone support help-lines?

There may be some risk to the psychological well-being of the participants after the face to face interviews. The information pack and debrief sheet will both contain contact details of the participants Deanery where they can access counselling services. The name of the researcher and the researcher's supervisor will also be included.

There is a risk that the participants may disclose that they were involved in a serious incident that was not reported. This could have legal or professional implications for them. The researcher contacted the UEL Academic Legal Department who advised to inform participants, upon recruitment, that they should <u>not</u> disclose this information but if they do, confidentiality would have to be broken and the university and the deanery informed (please see attached).

25. Protection of the researcher:

Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you and how will you mitigate this? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

For any interviews that are conducted in isolation, the researcher's supervisor will be informed of place, time and when the researcher has left.

26. Debriefing participants:

How will participants be de-briefed? Will participants be informed about the true nature of the research if they are not told beforehand? Will contact details of a support organisation be made available to participants via the debrief letter? <u>All student research must involve a debrief letter for participants (unless the research involves anonymous surveys) so please attach a copy of your debrief letter to this application (see page 12)</u>.

All participants will be provided with a debrief sheet that will include instructions as to how to contact their deanery's counselling services, the researcher and the researcher's supervisor. (see attached).

27. Other: Is there anything else the reviewer of this application needs to know to make a properly informed assessment?

No

28. Will your research involve working with children or vulnerable adults?*

YES / <u>**NO**</u>

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

YES / [✓ NO]

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas?

YES / [✓ NO]

This includes collecting data while you are away from the UK on holiday or visiting your country of origin, and distance learning students who will be collecting data in their overseas country of residence.

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: *Catherine Barton-Sweeney*

Student's number: U9603054 Date: 8th April 2019

Supervisor's declaration of support is given upon their electronic submission of the application

YOU MUST ATTACH THESE ATTACHMENTS:

1. PARTICIPANT INVITATION LETTER(S)

See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in the write-up of the study, or at conferences or in possible publications etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application.

2. CONSENT FORM(S)

Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

3. PARTICIPANT DEBRIEF SHEET

This can be one or two paragraphs thanking participants, reminding them what will happen to their data and, if relevant, should include the contact details of a relevant agency or organisation that participants can contact for support if necessary. Should include the true nature of the study if your research involved deception.

OTHER ATTACHMENTS YOU MAY NEED TO INCLUDE:

See notes on Page 2 about what other attachments you may need to include – Example interview questions? Copies of questionnaires? Visual stimuli? Ethical clearance or permission from another institution or organisation? Current DBS clearance certificate?)

SCANNED COPY OF CURRENT DBS CERTIFICATE

(If one is required. See notes on Page 3)

Interview Schedule

Demographic Questions

Confirm contact details

What stage of medical training are you currently at?

Introduction Question

Please describe your experience of being a junior doctor

As you know, this project is about getting a better understanding of what it is like for junior doctors who have been involved in a serious incident. What was your experience of being involved in a serious incident?

Can you tell me which areas of your life were affected?

Was it emotionally, professionally, relationships, all of these? Please tell me about this.

Tell me about any available resources. Did you use them? Can you tell me more?

Why didn't you use them? Can you tell me more?

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and I am studying for a Professional Doctorate in Counselling Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into junior doctor's experiences of being involved in a serious incident and what they might perceive as barriers to seeking psychological services such as counselling.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to involve junior doctors in their first four years of post-graduate training (F1; F2; ST1; ST2) who have been involved in a serious incident that they have already reported to their Deanery and that have not sought psychological therapy.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to:

- Undertake a qualitative, semi-structured interview in relation to your experiences of what it was like to be involved in a serious incident and what you perceive to be the barriers to accessing psychological services such as counselling.

- The interview will be face to face with the researcher and will be audio-recorded, which will later be transcribed and explored using qualitative methodology.

- The interview will take no longer than two hours.

- The venue for the interviews will be at a non-NHS site and can be at a place of your choice, (provided we would not be interrupted, or if there was little other noise and that we would not be overheard), if that is more convenient.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times:

- Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.

- Participants do not have to answer all questions asked of them and can stop their participation at any time

- An exception to confidentiality will be if, during the interview, you disclose not having reported being involved in a serious incident. As this is a statutory requirement, there would be possible legal implications and I would need to inform both your deanery and my university.

What will happen to the information that you provide?

What I will do with the material you provide:

- Your name, contact details and any data collected will be stored in a password protected file on a password protected computer, both of which will only be accessible to the researcher

- Your name and contact details will not be linked to the data you provide. All names will be changed and pseudonyms will be used instead

- The anonymised data will be seen by my supervisor, examiners, and may be published in academic journals. In addition, presentations of the write up of the research, as a whole, may be delivered to various NHS organisations.

- Your name and contact details, stored on the computer, will be destroyed when the study is completed, when the researcher's viva voce is passed: The interview transcripts will be kept for six years, to enable write up for publication and presentation

What if you want to withdraw?

You are free to withdraw at any point during the interview and up until three-weeks after you participate in the study without explanation, disadvantage or consequence. However, if you withdraw after this period of time, I would reserve the right to use the material that you provided.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Catherine Barton-Sweeney

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:
Dr Stelios Gkouskos.
School of Psychology,
University of East London,
Water Lane,
London
E15 4LZ,
Email: s.gkouskos@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee:
Dr Tim Lomas,
School of Psychology,
University of East London,
Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

UNIVERSITY OF EAST LONDON

Consent to Participate in a Research Study

What is the Lived Experience for Junior Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from Seeking Psychological Assistance?

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. However, if I withdraw 3 weeks after having taken part in the study, the researcher would reserve the right to use the material that I provided.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

…………………………………………………………………………………………..

Researcher’s Signature

……………………………………………………………………………………………

Date: ……………………..…….

PARTICIPANTS DEBRIEF SHEET

Thank you for taking part in this research

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Catherine Barton-Sweeney

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:

Dr Stelios Gkouskos.
School of Psychology,
University of East London,
Water Lane,
London E15 4LZ,
Email: s.gkouskos@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas,
School of Psychology,
University of East London,
Water Lane,
London E15 4LZ.
Email: t.lomas@uel.ac.uk

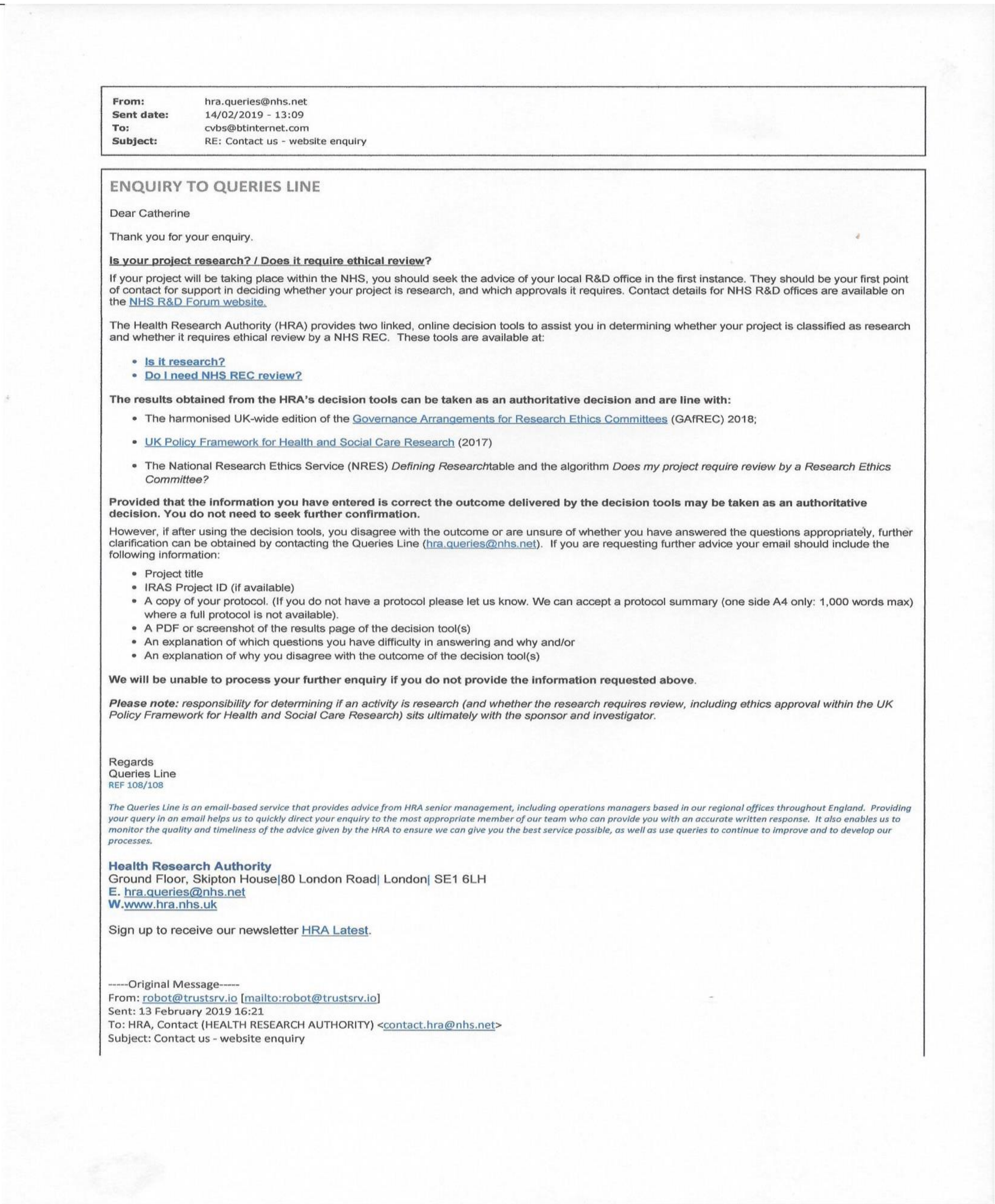
Your local Professional Support Unit can provide psychological support including counselling:

London and South East
Postgraduate Medical and Dental Education
Professional Support Unit

Email: psu.lase@hee.nhs.uk

The BMA provides a wellbeing support service. This includes confidential counselling and peer support that is open 24/7 to all doctors and medical students. For more information please see:

https://www.bma.org.uk/advice/work-life-support/your-wellbeing
Email: wellbeingsupport@bma.org.uk



From: hra.queries@nhs.net
Sent date: 14/02/2019 - 13:09
To: cvbs@btinternet.com
Subject: RE: Contact us - website enquiry

ENQUIRY TO QUERIES LINE

Dear Catherine

Thank you for your enquiry.

Is your project research? / Does it require ethical review?

If your project will be taking place within the NHS, you should seek the advice of your local R&D office in the first instance. They should be your first point of contact for support in deciding whether your project is research, and which approvals it requires. Contact details for NHS R&D offices are available on the NHS R&D Forum website.

The Health Research Authority (HRA) provides two linked, online decision tools to assist you in determining whether your project is classified as research and whether it requires ethical review by a NHS REC. These tools are available at:

- **Is it research?**
- **Do I need NHS REC review?**

The results obtained from the HRA's decision tools can be taken as an authoritative decision and are line with:

- The harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GAfREC) 2018;
- UK Policy Framework for Health and Social Care Research (2017)
- The National Research Ethics Service (NRES) *Defining Research*table and the algorithm *Does my project require review by a Research Ethics Committee?*

Provided that the information you have entered is correct the outcome delivered by the decision tools may be taken as an authoritative decision. You do not need to seek further confirmation.

However, if after using the decision tools, you disagree with the outcome or are unsure of whether you have answered the questions appropriately, further clarification can be obtained by contacting the Queries Line (hra.queries@nhs.net). If you are requesting further advice your email should include the following information:

- Project title
- IRAS Project ID (if available)
- A copy of your protocol. (If you do not have a protocol please let us know. We can accept a protocol summary (one side A4 only: 1,000 words max) where a full protocol is not available).
- A PDF or screenshot of the results page of the decision tool(s)
- An explanation of which questions you have difficulty in answering and why and/or
- An explanation of why you disagree with the outcome of the decision tool(s)

We will be unable to process your further enquiry if you do not provide the information requested above.

Please note: *responsibility for determining if an activity is research (and whether the research requires review, including ethics approval within the UK Policy Framework for Health and Social Care Research) sits ultimately with the sponsor and investigator.*

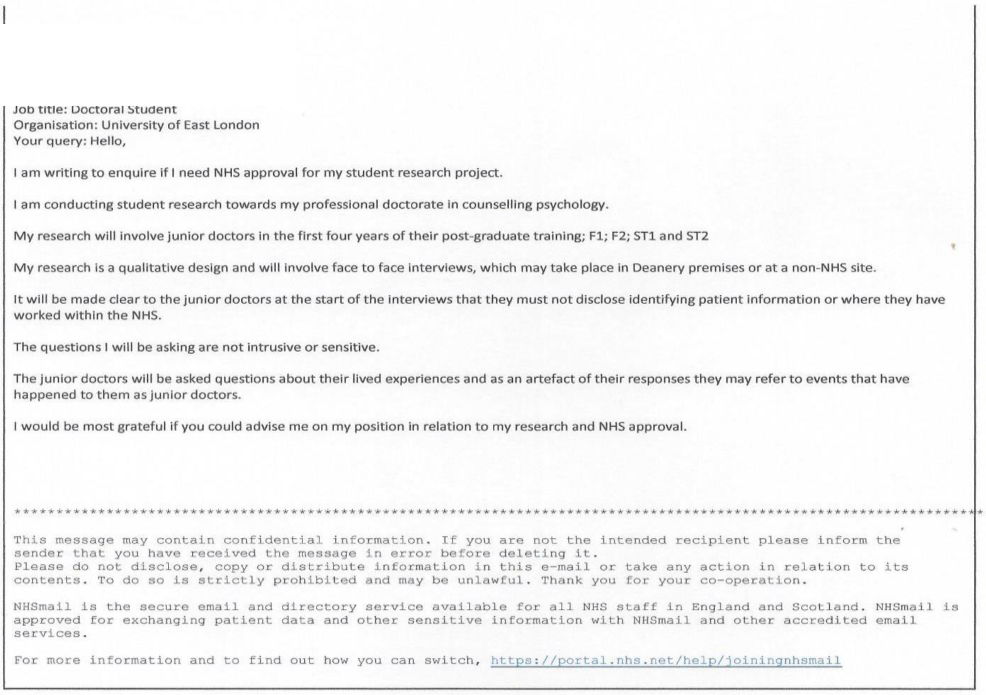
Regards
Queries Line
REF 108/108

The Queries Line is an email-based service that provides advice from HRA senior management, including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with an accurate written response. It also enables us to monitor the quality and timeliness of the advice given by the HRA to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Health Research Authority
Ground Floor, Skipton House|80 London Road| London| SE1 6LH
E. hra.queries@nhs.net
W.www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

-----Original Message-----
From: robot@trustsrv.io [mailto:robot@trustsrv.io]
Sent: 13 February 2019 16:21
To: HRA, Contact (HEALTH RESEARCH AUTHORITY) <contact.hra@nhs.net>
Subject: Contact us - website enquiry



Job title: Doctoral Student
Organisation: University of East London
Your query: Hello,

I am writing to enquire if I need NHS approval for my student research project.

I am conducting student research towards my professional doctorate in counselling psychology.

My research will involve junior doctors in the first four years of their post-graduate training; F1; F2; ST1 and ST2

My research is a qualitative design and will involve face to face interviews, which may take place in Deanery premises or at a non-NHS site.

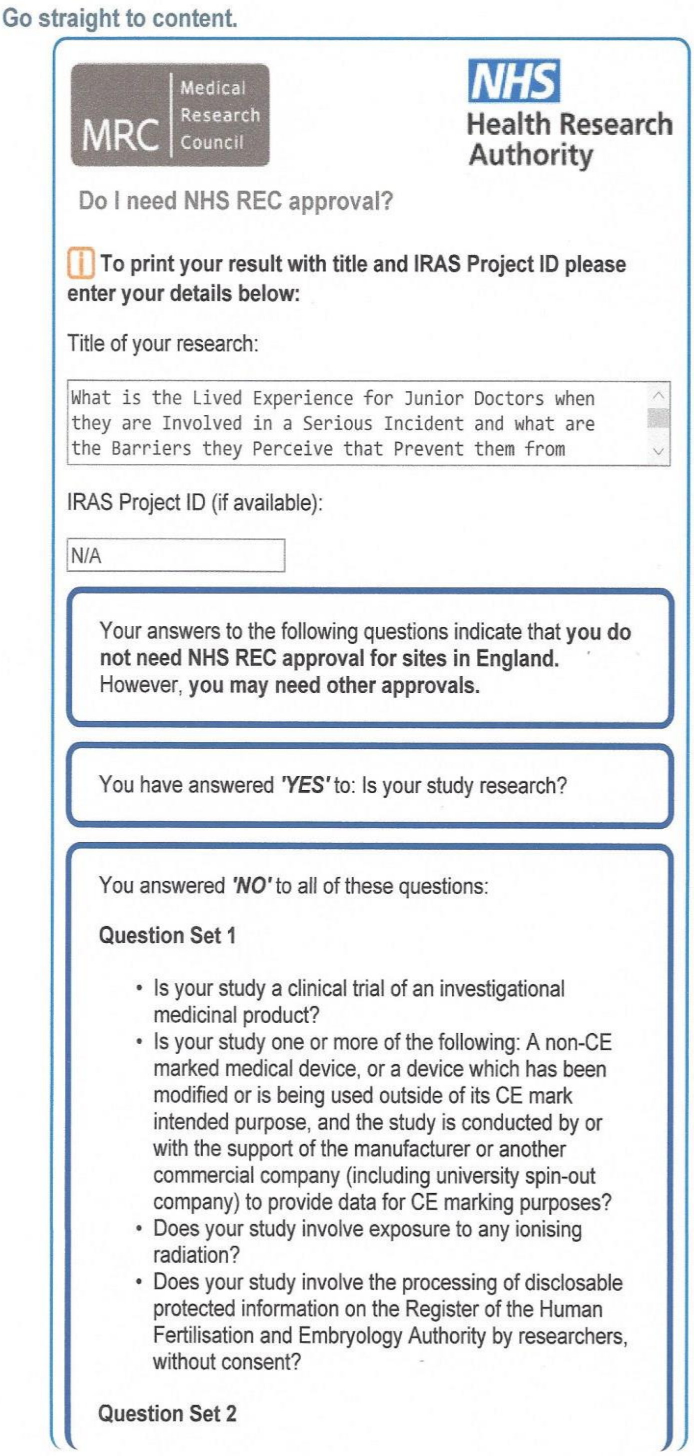
It will be made clear to the junior doctors at the start of the interviews that they must not disclose identifying patient information or where they have worked within the NHS.

The questions I will be asking are not intrusive or sensitive.

The junior doctors will be asked questions about their lived experiences and as an artefact of their responses they may refer to events that have happened to them as junior doctors.

I would be most grateful if you could advise me on my position in relation to my research and NHS approval.

****



Go straight to content.

MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

What is the Lived Experience for Junior Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from

IRAS Project ID (if available):

N/A

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

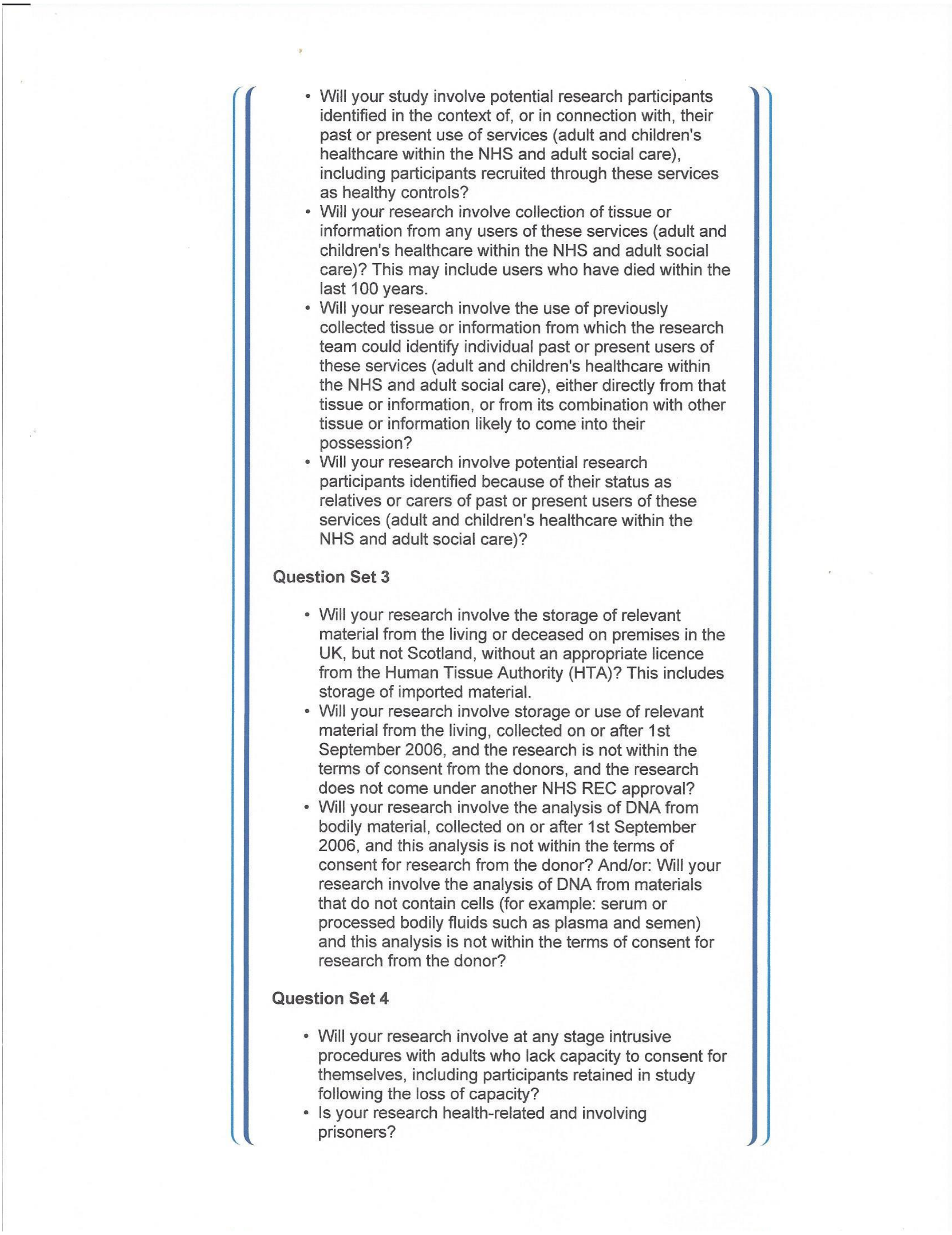
You have answered ***'YES'*** to: Is your study research?

You answered ***'NO'*** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?

Question Set 2



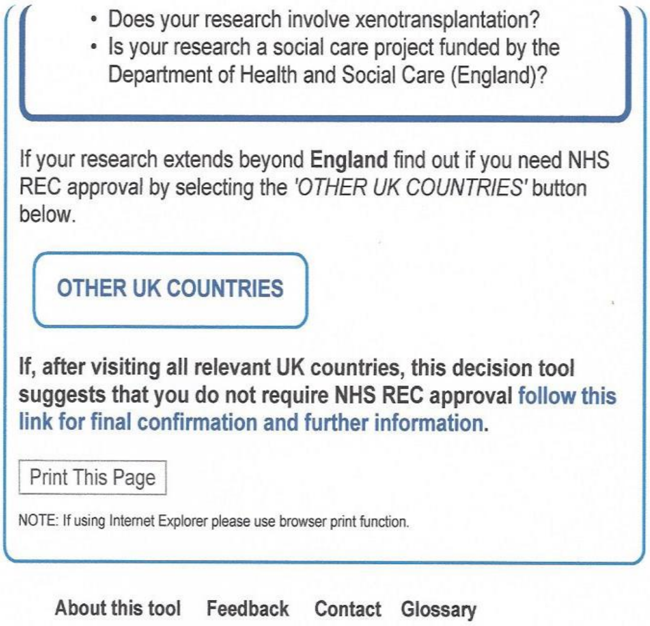
- Will your study involve potential research participants identified in the context of, or in connection with, their past or present use of services (adult and children's healthcare within the NHS and adult social care), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve potential research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor? And/or: Will your research involve the analysis of DNA from materials that do not contain cells (for example: serum or processed bodily fluids such as plasma and semen) and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?



- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health and Social Care (England)?

If your research extends beyond **England** find out if you need NHS REC approval by selecting the *'OTHER UK COUNTRIES'* button below.

If, after visiting all relevant UK countries, this decision tool suggests that you do not require NHS REC approval follow this link for final confirmation and further information.

NOTE: If using Internet Explorer please use browser print function.

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Lorna Farquharson

SUPERVISOR: **Stelios Gkouskos**

STUDENT: Catherine Barton-Sweeney

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: What the experience of being involved in a SI is for junior doctors and what they think might be the barriers to seeking psychological help

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

2. Approved, but minor amendments are required before the research commences.

Minor amendments required *(for reviewer)*:

The debrief sheet would benefit from more relevant information on how to access support, if needed. Although the professional support unit contact details are included, it's not clear what support could be provided. Could a line or two be included with a weblink?

Also, the BMA wellbeing support services are likely to be more relevant and helpful than the information available on the Mind website. Please see the following link for further information https://www.bma.org.uk/advice/work-life-support/your-wellbeing

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Lorna Farquharson

Date: 18.04.19

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. t.lomas@uel.ac.uk).

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the ‘student’s signature’ section (page 2).
9. When submitting this request form, ensure that all necessary documents are attached (see below).
10. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at t.lomas@uel.ac.uk
11. Your request form will be returned to you via your UEL email address with reviewer’s response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
12. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

4. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
5. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
6. A copy of the approval of your initial ethics application.

Name of applicant: Catherine Barton-Sweeney Programme of study: Professional doctorate Counselling Psychology Title of research: What is the Lived Experience for Junior Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from Seeking Psychological Assistance? A Descriptive Phenomenological Analysis. Name of supervisor: Dr Stelios Gkouskos

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
To change the inclusion criteria for research participation from junior doctors to all doctors on the General Medical Council's (GMC) full register.	All doctors are at risk of being involved in a serious incident. By changing the inclusion criteria, it opens the potential for a wider selection of doctors to take part in the research. However, it now excludes newly qualified doctors who are only provisionally registered with the GMC. The rationale for this exclusion is that their reduced registration and clinical experience means that they are closely supervised and therefore, it is less likely that they would be directly involved in a serious incident.
To change the participant sample size from 12 - 15 to 4 - 15	The practicalities of engaging busy medics may require more time than is permitted. This proposed change will not undermine the research. Giorgi (2009) stated that within the descriptive phenomenological framework, rich data can be achieved with three or more participants Giorgi, A. (2009). The descriptive

	phenomenological method in psychology: A modified Husserlian approach. Pittsburgh, PA: Duquesne University Press.
To change the title of the research to: What is the Lived Experience for Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from Seeking Psychological Assistance? A Descriptive Phenomenological Analysis.	If the above changes are approved, the title of the research will need to be changed to reflect the changes.

Please tick	**YES**	**NO**
Is your supervisor aware of your proposed amendment(s) and agree to them?	√	

Student's signature (please type your name): Catherine Barton-Sweeney

Date: 01/10/2019

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 1.10.19

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

If you need to apply for ethical clearance from HRA (through IRIS) for research involving the NHS you DO NOT need to apply to the School of Psychology for ethical clearance also. Please see details on https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/NHS-Research-Ethics-Committees.aspx

Among other things this site will tell you about UEL sponsorship

PLEASE NOTE that HRA approval for research involving NHS employees is not required when data collection will take place off NHS premises and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

If you are employed by the NHS and plan to recruit participants from the NHS Trust you work for, it please seek permission from an appropriate person at your place of work (and better to collect data off NHS premises).

PLEASE NOTE that the School Research Ethics Committee does not recommend BSc and MSc/MA students designing research that requires HRA approval for research involving the NHS as this can be a demanding and lengthy process.

Before completing this application please familiarise yourself with:

The *Code of Ethics and Conduct (2018)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-

%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

And please also see the UEL Code of Practice for Research Ethics (2015-16)
https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Documents/Ethics%20forms/UEL-Code-of-Practice-for-Research-Ethics-2015-16.pdf

HOW TO COMPLETE & SUBMIT THIS APPLICATION

13. Complete this application form electronically, fully and accurately.

14. Type your name in the ‘student’s signature’ section (5.1).

15. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc**

16. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. Your supervisor will then look over your application.

17. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the ‘supervisor’s signature’ (section 5) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

18. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See section 4)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

7. A copy of the participant invitation letter that you intend giving to potential participants.
8. A copy of the consent form that you intend giving to participants.
9. A copy of the debrief letter you intend to give participants.

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external institution or organisation if you need it (e.g. a charity, school, local authority, workplace etc.). Permissions must be attached to this application. If you require ethical clearance from an external organisation your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation (see Section 5).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. If you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice.

- DBS clearance is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Tim Lomas (Chair of the School Research Ethics Committee) at t.lomas@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see Section 4 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another for the duration of your studies in order to conduct research with vulnerable populations.

Please read all guidance notes in blue carefully to avoid incorrect or insufficient applications

If yours is an online study using Qualtrics please see the example ethics application in the Ethics folder in the Psychology Noticeboard

SECTION 1. Your details

11. Your name: Catherine Barton-Sweeney

12. Your supervisor's name: Dr Stelios Gkouskos

13.Title of your programme: Professional Doctorate in Counselling Psychology

14.Submission date for your BSc/MSc/MA research: August 2020

15.Please tick if your application includes a copy of a DBS certificate (see page 3) ☐

16.Please tick if your research requires DBS clearance but you are a Prof Doc student and have applied for DBS clearance – or had existing clearance verified – when you registered on your programme (see page 3)

☐

17.Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Tim Lomas for confidentiality reasons (Chair of the School Research Ethics Committee) t.lomas@uel.ac.uk ☐

18.Please tick to confirm that you have read and understood the British Psychological Society's Code of Ethics and Conduct (2009) and the UEL Code of Practice for Research Ethics (See links on page 1)

☑

SECTION 2. About your research

19.What your proposed research is about:

Please be clear and detailed in outlining what your proposed research is about. Include the research question (i.e. what will your proposed investigate?)

Whilst it is acknowledged that patients and their family or carers are the primary concern when a serious clinical incident occurs, Professor Albert Wu, suggested that the doctors involved are also "wounded by the same errors" and, as such, are "second victims". In his article, Wu described the traumatising effect that being involved in a SI can have upon doctors. This led to research that examined the impact of the second victim phenomenon.

This research provided overwhelming evidence that being involved in a SI can undermine the psychological wellbeing of doctors to such an extent that some manifest persistent symptoms including those of post-traumatic stress disorder (PTSD).
In terms of recommendations for support for those involved in SIs, counselling has not been considered a priority and it is unclear why not.

Therefore, It is proposed that this research will endeavour to explore what the experience of being involved in a SI is for doctors

20.Design of the research:

Type of experimental design, variables, questionnaire, survey etc., as relevant to your research. If the research is qualitative what approach will be used and what will the data be?

This will be a qualitative research design, using a descriptive phenomenological approach.

The data will be audio-recorded and transcribed one to one semi-structured interviews.

10. Recruitment and participants (Your sample):

Proposed number of participants, method/s of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research.

It is proposed that 4 – 15 participants will be sought.

The participants will be recruited through email request.

The participants will be doctors with full General Medical Council (GMC) registration and who have been involved in at least one SI, these are the only specific characteristics being sought.

11. Measures, materials or equipment:

Give details about what will be used during the course of the research. For example: equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application.

Face to face participant led interviews will be undertaken and audio recorded using a tape recorder.

An interview schedule will be used (please see attached)

12. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / [✓ NA]

13. Outline the data collection procedure involved in your research:

Describe in detail what will be involved in data collection. For example, what will participants be asked to do, where, and for how long? If using online surveys will you be using Qualtrics? Detail what you will include in the Qualtrics page that you intend to make available to potential participants (see the example ethics application for a student study using Qualtrics in the Ethics folder of the Psychology Noticeboard).

Participants will be asked to attend face to face interviews and answer the research questions.
The interviews will last no longer than two hours.
The venue for the interviews will be non-NHS

SECTION 3. Ethical considerations

14. Fully informing participants about the research (and parents/guardians if necessary):

How will you fully inform your participants when inviting them to participate? Will the participant invitation letter be written in a style appropriate for children and young people, if necessary?

The participant invitation pro-forma will be used (please see attached).

All participants will be adults over the age of eighteen.

15. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Is the consent form written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians? How will you gain consent if your research is collecting data online (e.g. using Qualtrics)?

The consent pro-forma will be used (please see attached).

16. Engaging in deception, if relevant:

What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.

Participants will be told about the nature of the research. No information will be withheld from the participants at any time.

17. Right of withdrawal:

In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve (1) participants being able to decide to not continue with participation in your research, and (2) the right to have the data they have supplied destroyed on request. You are asked to give participants a three-week window from the time they participate in your study to when they can withdraw their data. Make this clear in your participant invitation letter.

Note: If your study involves data collection through Qualtrics, it is essential that you ask participants to provide their own participant code on Qualtrics (e.g. two letters and two numbers) so that you will be able to identify them if they later want to withdraw their data.

The right of withdrawal, as stated above, will be made clear to participants in the invitation letter.

As recommended above, participants will be given a three-week window from the time they take part in the research to when they can withdraw.

18. Will the data be gathered anonymously?

This is where you will not know the names and contact details of your participants? In qualitative research that involves interviews, data is not collected anonymously because you will know the names and contact details of your participants.

YES / [✓ **NO**]

19. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually data will be destroyed after a study is over but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? (suggested time is two years). It is advised that you destroy all names and contact details of participants at the end of your study regardless of how long will keep your data for. Make this clear in your participant invitation letter.

The names and contact details of participants will be kept in a password protected file on the researcher's personal computer for which access, is also password protected. Only the researcher will have access to the participants names and contact details. Real names and any identifying references will be omitted from the reporting of data and transcripts etc.

Once the study is completed and the researcher has passed their viva voce, all names and contact details of participants will be destroyed. The transcript of the anonymised interviews and analysis will be stored, under password protection as described above, because the researcher intends to develop their research for publication. This remaining data will be destroyed after six-years, from the end of the study or the required timeframe of a publishing journal, if different.

20. Will participants be paid or reimbursed?

This is not necessary, but payment/reimbursement must be in the form of redeemable vouchers and not cash. Please note that the School cannot fund participant payment.

YES / [✓ **NO**]

If YES, why is payment/reimbursement necessary and how much will the vouchers be worth?

SECTION 4. Other permissions and ethical clearances

21. Research involving the NHS in England

Is HRA approval for research involving the NHS required? YES / [✓ NO]
Please see Page 1 of this application for important information and link

Will the research involve NHS employees who will not be directly recruited through the NHS and where data from NHS employees will not be collected on NHS premises?

The participants are NHS employees. The interviews will not take place in NHS premises. The researcher enquired of the HRA if approval was required and was directed towards an electronic questionnaire, which when completed indicated approval was not required (please see attached).

If you work for an NHS Trust and plan to recruit colleagues from the Trust will permission from an appropriate member of staff at the Trust be sought and is a copy of this permission (can be an email from the Trust) attached to this application?

YES / NO/[✓ N/A]

22. Permission(s) from an external institution/organisation (e.g. a school, charity, workplace, local authority, care home etc.)?

You need to attach written permission from external institutions/organisations/workplaces if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation.

Is permission from an external institution/organisation/workplace required? / NO

If YES please give the name and address of the institution/organisation/workplace:

COPIES OF PERMISSIONS (LETTER OR EMAIL) MUST BE ATTACHED TO THIS APPLICATION

In some cases you may be required to have formal ethical clearance from the external institution or organisation or workplace too.

23. Is ethical clearance required from any other ethics committee?

YES / [✓ NO]

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? YES / NO

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation confirming its ethical clearance is acceptable.

Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

SECTION 5. Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible.

If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

24. Protection of participants:

Are there any potential hazards to participants or any risk of accident or injury to them? What is the nature of these hazards or risks (can be physical, emotional or psychological)? How will the safety and well-being of participants be ensured? Will contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?

The support organisation or agency that you refer participants to in your debrief letter should be appropriate. That is, is there a more appropriate support organisation than the Samaritans, for example (i.e. anxiety, mental health, young people telephone support help-lines?

There may be some risk to the psychological well-being of the participants after the face to face interviews. The information pack and debrief sheet will both contain contact details of where participants can access counselling services. The name of the researcher and the researcher's supervisor will also be included.

There is a risk that the participants may disclose that they were involved in a serious incident that was not reported. This could have legal or professional implications for them. The researcher contacted the UEL Academic Legal Department who advised to inform participants, upon recruitment, that they should not disclose this information but if they do, confidentiality would have to be broken and the university and the deanery informed (please see attached).

25. Protection of the researcher:

Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you and how will you mitigate this? If interviewing participants in their homes will a third party be told of place and time and when you have left a participant's house?

For any interviews that are conducted in isolation, the researcher's supervisor will be informed of place, time and when the researcher has left.

26. Debriefing participants:

How will participants be de-briefed? Will participants be informed about the true nature of the research if they are not told beforehand? Will contact details of a support organisation be made available to participants via the debrief letter? All student research must involve a debrief letter for participants (unless the research involves anonymous surveys) so please attach a copy of your debrief letter to this application (see page 12).

All participants will be provided with a debrief sheet that will include instructions as to how to contact counselling services, the researcher and the researcher's supervisor. (see attached).

27. Other: Is there anything else the reviewer of this application needs to know to make a properly informed assessment?

No

28. Will your research involve working with children or vulnerable adults?*

YES / [✓ NO]

If YES have you obtained and attached a DBS certificate? YES / NO

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

YES / [✓ NO]

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely

consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see:

https://uelac.sharepoint.com/ResearchInnovationandEnterprise/Pages/Research-involving-children.aspx

29 Will you be collecting data overseas? YES / [✓ NO]
This includes collecting data while you are away from the UK on holiday or visiting your country of origin, and distance learning students who will be collecting data in their overseas country of residence.

If YES in what country or countries (and province if appropriate) will you be collecting data?

Please click on this link https://www.gov.uk/foreign-travel-advice and note in the space below what the UK Government is recommending about travel to that country/province (Please note that you MUST NOT travel to a country/province/area that is deemed to be high risk or where essential travel only is recommended by the UK Government. If you are unsure it is essential that you speak to your supervisor or the UEL Travel Office – travelúel.ac.uk / (0)20 8223 6801).

SECTION 6. Declarations

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: *Catherine Barton-Sweeney*

Student's number: U9603054 Date: 8th April 2019

Supervisor's declaration of support is given upon their electronic submission of the application

YOU MUST ATTACH THESE ATTACHMENTS:

4. PARTICIPANT INVITATION LETTER(S)

See pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This can be adapted for your own use and must be adapted for use with parents/guardians and children if they are to be involved in your study.

Care should be taken when drafting a participant invitation letter. It is important that your participant invitation letter fully informs potential participants about what you are asking them to do and what participation in your study will involve – what data will be collected, how, where? What will happen to the data after the study is over? Will anonymised data be used in the write-up of the study, or at conferences or in possible publications etc.? Tell participants about how you will protect their anonymity and confidentiality and about their withdrawal rights.

Make sure that what you tell potential participants in this invitation letter matches up with what you have said in the application.

5. CONSENT FORM(S)

Use the pro forma in the ethics folder in the Psychology Noticeboard on Moodle. This should be adapted for use with parents/guardians and children.

6. PARTICIPANT DEBRIEF SHEET

This can be one or two paragraphs thanking participants, reminding them what will happen to their data and, if relevant, should include the contact details of a relevant agency or organisation that participants can contact for support if necessary. Should include the true nature of the study if your research involved deception.

OTHER ATTACHMENTS YOU MAY NEED TO INCLUDE:

See notes on Page 2 about what other attachments you may need to include – Example interview questions? Copies of questionnaires? Visual stimuli? Ethical clearance or permission from another institution or organisation? Current DBS clearance certificate?)

SCANNED COPY OF CURRENT DBS CERTIFICATE

(If one is required. See notes on Page 3)

Interview Schedule

Demographic Questions

Confirm contact details

Can you tell me how long you have been a fully registered GMC doctor for?

Introduction Question

Please describe your experience of being a doctor

As you know, this project is about getting a better understanding of what it is like for doctors who have been involved in a serious incident. What was your experience of being involved in a serious incident?

Can you tell me which areas of your life were affected?

Was it emotionally, professionally, relationships, all of these? Please tell me about this.

Tell me about any available resources. Did you use them? Can you tell me more?

Why didn't you use them? Can you tell me more?

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and I am studying for a Professional Doctorate in Counselling Psychology. As part of my studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research into doctors' experiences of being involved in a serious incident and what they might perceive as barriers to seeking psychological services such as counselling.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

I am looking to involve doctorswho have full GMC registration and who have been involved in a serious incident that they have already reported to the required NHS departments and that have not sought psychological therapy.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to:

- Undertake a qualitative, semi-structured interview in relation to your experiences of what it was like to be involved in a serious incident and what you perceive to be the barriers to accessing psychological services such as counselling.

- The interview will be face to face with the researcher and will be audio-recorded, which will later be transcribed and explored using qualitative methodology.

- The interview will take no longer than two hours.

- The venue for the interviews will be at a non-NHS site and can be at a place of your choice, (provided we would not be interrupted, or if there was little other noise and that we would not be overheard), if that is more convenient.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of my research topic

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times:

- Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.

- Participants do not have to answer all questions asked of them and can stop their participation at any time

- An exception to confidentiality will be if, during the interview, you disclose not having reported being involved in a serious incident. As this is a statutory requirement, there would be possible legal implications and I would need to inform both the GMC and my university.

What will happen to the information that you provide?

What I will do with the material you provide:

- Your name, contact details and any data collected will be stored in a password protected file on a password protected computer, both of which will only be accessible to the researcher

- Your name and contact details will not be linked to the data you provide. All names will be changed and pseudonyms will be used instead

- The anonymised data will be seen by my supervisor, examiners, and may be published in academic journals. In addition, presentations of the write up of the research, as a whole, may be delivered to various NHS organisations.

- Your name and contact details, stored on the computer, will be destroyed when the study is completed, when the researcher’s viva voce is passed: The interview transcripts will be kept for six years, to enable write up for publication and presentation

What if you want to withdraw?

You are free to withdraw at any point during the interview and up until three-weeks after you participate in the study without explanation, disadvantage or consequence. However, if you withdraw after this period of time, I would reserve the right to use the material that you provided.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Catherine Barton-Sweeney

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:
Dr Stelios Gkouskos.
School of Psychology,
University of East London,
Water Lane,
London
E15 4LZ,
Email: s.gkouskos@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee:
Dr Tim Lomas,
School of Psychology,
University of East London,
Water Lane, London E15 4LZ.
(Email: t.lomas@uel.ac.uk)

UNIVERSITY OF EAST LONDON

Consent to Participate in a Research Study

What is the Lived Experience for Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from Seeking Psychological Assistance?

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. However, if I withdraw 3 weeks after having taken part in the study, the researcher would reserve the right to use the material that I provided.

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………..

Participant's Signature

………………………………………………………………………………………

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………………..

Researcher’s Signature

……………………………………………………………………………………………

Date: ……………………..…….

PARTICIPANTS DEBRIEF SHEET

Thank you for taking part in this research

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Catherine Barton-Sweeney

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:
Dr Stelios Gkouskos.
School of Psychology,
University of East London,
Water Lane,
London E15 4LZ,
Email: s.gkouskos@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas,
School of Psychology,
University of East London,
Water Lane,
London E15 4LZ.
Email: t.lomas@uel.ac.uk

The BMA provides a wellbeing support service. This includes confidential counselling and peer support that is open 24/7 to all doctors. For more information please see:
https://www.bma.org.uk/advice/work-life-support/your-wellbeing
Email: wellbeingsupport@bma.org.uk

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

19. Complete the request form electronically and accurately.
20. Type your name in the ‘student’s signature’ section (page 2).
21. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
22. Your request form will be returned to you via your UEL email address with reviewer’s response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

10. A copy of the approval of your initial ethics application.

Name of applicant:	Catherine Barton-Sweeney
Programme of study:	Professional Doctorate Counselling psychology
Name of supervisor:	Stelios Gkouskos

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: What is the lived experience for doctors when they are involved in a serious incident and what are the barriers they perceive that prevent them from seeking psychological assistance. A descriptive phenomenological analysis	The title has been changed because the second part: “and what are the barriers they perceive that prevent them from seeking psychological assistance” was a research aim rather than a core part of the research.
New Title: What is the lived experience for doctors when they are involved in a serious incident? A descriptive phenomenological analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student’s signature (please type your name): Catherine Barton-Sweeney

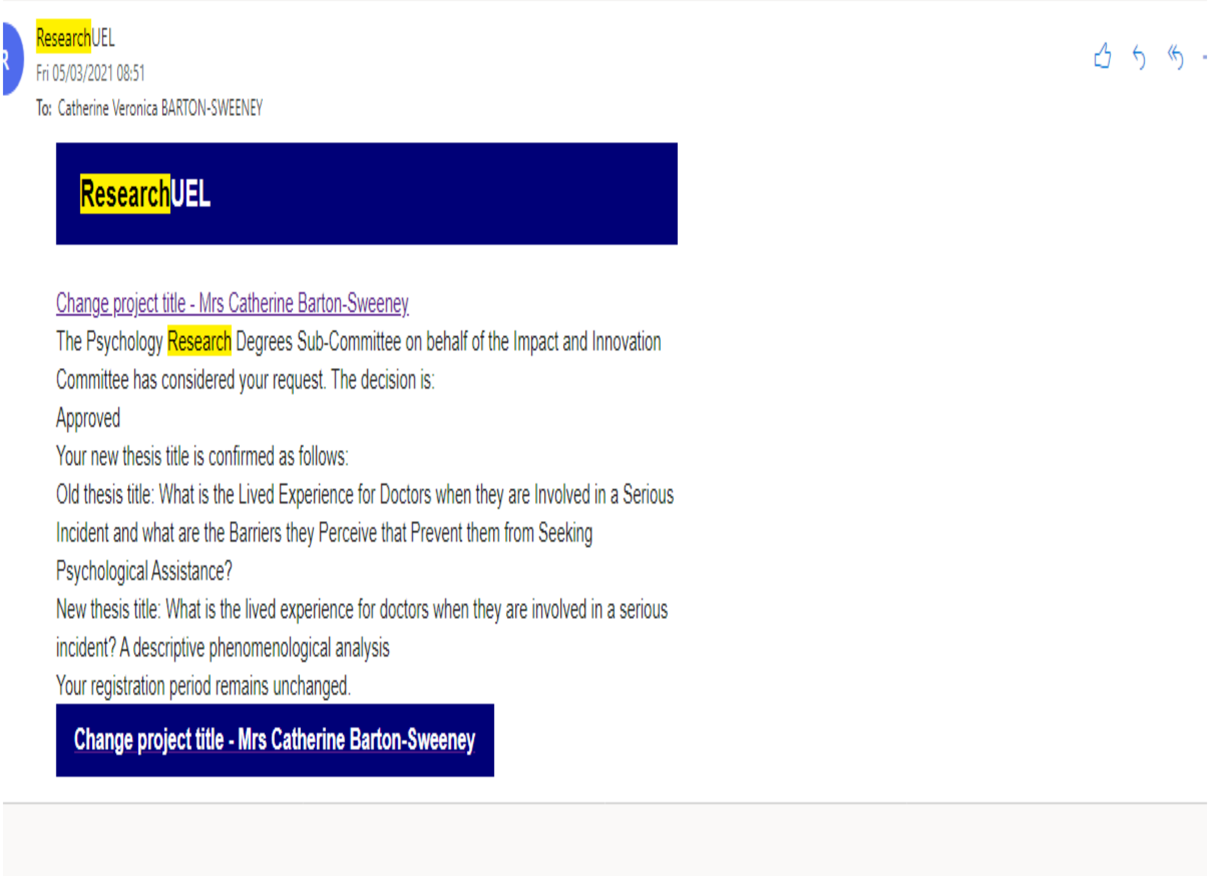
Date: 22.02.2021

TO BE COMPLETED BY REVIEWER		
Title changes approved		
Comments		

Reviewer:

Date:

Change of Thesis Title approval Email



ResearchUEL
Fri 05/03/2021 08:51
To: Catherine Veronica BARTON-SWEENEY

ResearchUEL

Change project title - Mrs Catherine Barton-Sweeney

The Psychology Research Degrees Sub-Committee on behalf of the Impact and Innovation Committee has considered your request. The decision is:

Approved

Your new thesis title is confirmed as follows:

Old thesis title: What is the Lived Experience for Doctors when they are Involved in a Serious Incident and what are the Barriers they Perceive that Prevent them from Seeking Psychological Assistance?

New thesis title: What is the lived experience for doctors when they are involved in a serious incident? A descriptive phenomenological analysis

Your registration period remains unchanged.

Appendix B: Literature Search Strategy

I conducted the search by identifying key words and then combining them in a variety of ways to search the available research databases as outlined below. The literature was searched for relevance to the second victim phenomenon through the EBSCO and Psychinfo research database facilities, via the My Athens website. Google Scholar and ResearchGate were also used. I searched the NICE website for relevant guidance to trauma as well as NHS Employers, NHS England and NHS Improvement for the various policies and procedures referred to in my thesis.

Appendix C: Example of Meaning Units

Taken from George's transcript: line 68, p. 3 (end of meaning unit depicted by bold word and /)

Well, it was a July day, a Thursday afternoon where we used to shut the surgeries on Thursdays and—well, Thursday afternoons, it was the days when it was half day closing but one of us to be on-call and I was I was in the—well, we're on-call, we were always in the building and I got a call late on a, on a Thursday evening to go and see a lady who was mid 40s with abdominal **pain**/, and what I hadn't realised which was perhaps relevant afterwards is she'd been seen twice. My, my my partner, John, had spoken to her and she'd been seen by the out of hours on the **Tuesday**/. So, this was a sunny July, Thursday afternoon, and she was in a bedroom, emmm. I, emm, I don't know if I'd met her before, a lovely lady, eh, but I met her husband before emm complaining of lower abdominal **pain**/. I thought it was, I thought it was probably a urinary tract infection. I examined her, she hadn't got any localising sort of surgical signs, emmm. Tested the urine, it was quite heavily stained with blood but she volunteered that she was menstruating. Emm I thought she'd probably got a urinary tract infection and in those days, we carried emmm starter packs of antibiotics, I gave her the starter pack, gave her a prescription, left her that and I said okay, you know, let's see how things **roll**/. The following morning then, there was another call, I thought oh what's going on there, so I rang, her husband she'd been really poorly overnight, she was seen by the out of hours at midnight, emmm, can you come and have another look at her? And I said there's no problem, I mean, there was no emm friction in terms of, you know, turning down, refusing to house calls or anything like **that**/. And then I recall most about it is

I went in and she was in a different bedroom and she was in a—she'd been in her own bedroom, I think, the night before and she was in her son's bedroom which was very, very blue, blue curtains so that the lighting in the room was blue. And I went in and said, "Oh…" Jane is her name, I said "Hey Jane, what's up?" and all I did was put my hand on her tum, and she gasped…I thought, oh she's, there's something definitely going on here and I thought that she probably got an acute appendicitis. So, I remember ringing, ringing the eh, the, the on-call surgical team and say I think it's [inaudible] and they say**, fine**/, [inaudible]. So, I was sitting there thinking I'm missing something **here**/ and then I went in and thought, right, yeah you know, blue, open the curtains and she was still blue. Oh god, what's going on here? So then—because all the time we'd been really, you know, I had made the assessment the night before, this is building on, I went in and there's much more going on here, do a blood pressure and blood pressures were in her boots I'm thinking, oh Christ, you know, she's she's got sepsis, **whatever**/. On those days, we carried—*well, I* carried, like giving sets of fluids and all sorts of stuff, an ambulance service and we were talking about 1989, July 1989, you know, the ambulance service was very much scoot and shoot, you didn't really have paramedics. So, I—I and I was still doing casualty sessions so emmm, I've got a bag of saline and line and put a line up, rang the am… 999 I think then the ambulance service had just arranged this … can you do this now as an immediate, and in fairness to them they responded very quickly. Emmm, actually wrapped her in a space blanket to try and maintain things, legs up. Got her in to M **Hospital**/ emmm at that stage I wasn't at all sure what had going **on**/. Emm she went through the next day [cough] ended up having—it turned out that she'd got a tubo-ovarian abscess on the right-hand side which is why I was thinking appendicitis. Emmm, unfortunately, the, because she was menstruating, she continued to bleed, they took her to theatre trying to, tried to emmm control things by eh giving her hysterectomy [participant visibly upset] but unfortunately, she died on the table from something called a DIC which is disseminated intravascular coagulation where you *lose* all your clotting products, she simply bled to **death**/. So emm I heard about—I can't remember how I heard, I think I might have rung that but anyway, the short and tall of it is I had a very emotional morning on the Sunday, because she passed away on the Sunday, and John, my senior partner and I went for a drink and I was probably mmm [participant pauses and is tearful] this close to packing in as **a**/ [inaudible] [participant tearful, visibly upset]. And it was, you know, you're back to the sort of emotional sort of attachment you have to your patients you're sitting there going, oh, you know, where did this come **from**?/ So, I thought, well, I've got to go and see, see them, so I went on the Monday morning to see them and Michael was fine, her husband. But his sister-in-law, her sister was gunning for **me**/. And so I then had a chat with him about how things have rolled out and explored a little bit further and realised that, not only is she had a contact with John on the Monday or Tuesday, she'd seen the out of hours doctor on the *Wednesday* which I didn't know anything about, and then also it seemed one of my colleagues on another one out of hours on midnight on the Thursday who in fact I knew very well who's an anaesthetist and GP, so I rang him and said, you know, did anything seem out of the **ordinary**/. And going back to the reason why she changed rooms is she had diarrhoea, so she'd soiled the bed in the other bedroom, which is why, **you know**/? Emmm, and I was, you know, pretty fresh out of hospital then, so I knew all the personalities involved; the, the gynaecologist who operated on her was a guy I'd worked for, the surgeon who'd, who'd been involved in it was also a fellow I knew pretty well, the intensivist who looked after her was a fellow that I'd known from med school, and *all* of them were very supportive. Because I went when I had a chance and said, you know, what happened, how did this roll **out**/, and the paradox about it is I'd probably resuscitated her too well, *at home* because by the time she got into M Hospital, she's got a blood pressure of 140 systolic whereas it'd been in her boots here but I mean she'd had nearly two litres of fluid because—but the first one happened, squeeze it through and but the second one… by the time the ambulance **arrived**/. Ehhh, and it rumbled—well, it didn't rumble on, I mean there was no complaint but it was more about how I felt about going through a process and seeing how something that appeared to be relatively straightforward suddenly exploding into a catastrophe and back to the feeling of knowing the family, there were two teenage children, a boy and a girl, they just had spent a, you know, fortune on extension on the back of the bungalow and all the rest of it. I mean, you know, their family life was [pause] fine and then suddenly, this absolutely shattered **things**/. And you had got this—Michael said, oh, my sister-in-law says we should complain but I'm perfectly happy what you did, you did everything you could. And I said, you know, you must do what you feel is right for you, I won't think anything, any different about you, if you feel you want to do it because, you know, there are questions that need to be answered, emmm but he **didn't**/. And the really perverse thing about it is probably two, two and a half years later, I had to go and see the sister who had also seen Ian Millington before who diagnosed a urinary tract infection. I went to see her in her home and you can imagine the atmosphere was quite cold, and I examined her and thought, oh my god, she's got a massive pelvic mass. And I just said, "Well, you need to go into hospital," "oh La, la, la, la," you know, but sort of you would say that wouldn't you and I thought, okay, and I said, "Listen, you know, I know that you have issues about what happened to your sister, I said, but we're not talking about your sister now, we're talking about you." Emm I had some, some significant difficulty in getting the gyne SHO to accept her, but I didn't take no for an answer. I sent her in, she [pause] went to theatre in a couple of days later and she had a massive ovarian cyst that ruptured at as they entered and she nearly exsanguinated on the table, and she turned out to actually have, emm, an ovarian carcinoma. But she had the grace to come and see me afterwards and say, oh I was wrong about you, you know, and funny enough then sort of always came to see me. Ehhh, she ended up having chemo and then she moved away but she did very **well**/. But it's it's really quite bizarre because it's almost like lightning striking twice, but it gave her an insight into just how things went, how things went completely tee up with her **sister**/. Emmm, [pause] but it took me a *very* long time to shake it off and I suppose, I become quite, quite defensive for a while. I managed to laugh it off in a way of saying, "Right, well…" you know, I said, "You know, on Friday the 13th, I'm not going to do any clinical work on Friday the 13th, so I teach or I take the day off."

I carry on doing that. It's just a standing joke **really**/.

Well, I was lucky in the sense that my wife has trained, so she had, you know, an appropriate insight into what I have done because, you know, she worked on surgical wards and she'd seen things go tee up. Emmm, I, so, I'm trying to think in '89, we had… Yeah, I had two sons and William was 18 months, Matthew was about a month old, you know, so the kids weren't affected by it **anyway**/. My partners were hugely supportive, [pause] and we worked in a group with another practise and they were equally supportive. I think I presented, I can't remember, didn't do a formal presentation where we certainly talked about **it**/, because the first time I come across someone with a DIC emmm—well, no, it wasn't actually, I'd seen one in Morriston where again unfortunately she died on the table as well, so like I was familiar with

that/. Emmm, and I [inaudible] you know, what helped? Undoubtedly, it was the fact that Michael her husband wasn't terribly well himself, he kept on coming to see me, so you know, it was an explicit statement of trust, if you like, which helped enormously. So, in some ways, we had a shared grieving **process**/.

Well, I think they …I mean, at that stage it was all in the front of my face. I mean, it was afterwards perhaps that the emmm… they, I mean, I remember speaking to John who was the intensivist and David, he qualified the year I started training in medicine so we overlapped quite fleetingly but I mean we played—he'd been the captain of the rugby club [inaudible] and so I got to know him quite well anyway. And his take on it was—I don't know how you guys do it, how do you spot something like this in the **community**/. So, very supportive about the challenge in recognising something at the start of a journey. Emmm Peter emmm the gyne consultant, I worked for him for six months and he just said, "Look, these things happen. You know, you didn't miss something, you acted on it." I mean, in cas [casualty/A&E] I mean I was still doing clinical assistant sessions on a Sunday evening there so I knew all the personalities involved **there**/. I'd redirected the ambulance from taking her to a surgical ward saying, "Look, bring her into cas [casualty/ A&E]," I said, "She needs to be resussed [resuscitated] we've got to get in to resuss [intensive care] her there." So, I was almost switching roles, you know, I followed the ambulance in and I went into recess. To a certain extent, I acted as a handing over clinician rather than the ambulance service because in those days, we didn't have paramedics, I mean they were ambulance boys, lovely guys but I remember saying, you know, have you got a space blanket, "What's a space blanket? No" I said, I got one in the boot of the car, you know, wrap her up in that, like just get her legs up and so forth. Emmm and so, I went through a lot of that [cough] almost on **autopilot**/, and it was only afterwards when things had happened that I went and thought, well, I've got to find some answers here, just find out what happened. Because, you know, instead of going from being someone who left the house with a [pause] recordable blood pressure and… you know, chatting away, she wasn't, she wasn't ill, it wasn't something as if she was sitting there and toxic or anything like that, though I [inaudible] with my first thing was, you know, was this sepsis, but it was actually hypovolemic, you know, she was exsanguinating until this thing had ruptured and the rest of it was—emmm, you know, the rest took its toll, if you **like**/. So, it was very much sort of, right, so having someone described what they found, I'm thinking, "Oh right, so that's what it was. Right, okay." And then, you know, I mean it's partly the differential… I mean as a general practitioner, you look and turn around and said, "Does this person need to be admitted?" "Yes." "Okay, well, let's get that sorted." We can worry about the *finer* points of the differential diagnosis; when she's in hospital, you know, she's got an acute surgical abdomen query cause, you know, and they weren't bickering about whether it was gyne or surgery at that **moment**/. I mean, and that was another reason for going to cas [casualty/A&E] really because saying that, you know, I'm not so sure what the hell's going on here so if she's worked up in cas [casualty/A&E] then we'll have a better idea. So, the three consultants have been involved, all are very **supportive**/. Emmm, I can't really think how it rolled on there, I mean I know I was—on the Sunday, I just felt like giving up medicine because you just thought like oh my god, you know, someone's died on my watch. I wrote it all down and stuck in the envelope, dated it, sealed it and put it in the drawer. But I wrote everything down because if something happens; I'm not trying to write a narrative about what happened, with something hanging over, I thought if I write it now, I write it in the here and now, if something happens, well, I'll just turn around and say, “There’s my, there’s my thought on this.” And it’s the only time, touch wood, I ever had to do that in practise where I sat and **thinking**/… And that was mainly because of the, the aggression from the sister who was, you know, she was raw, she was emotional, she was angry, and I was then, you know, “There are four bloody doctors who saw her. Four, four, hell of a four,” and then, you know, transpired that she’d be… Because we never got handovers from the deputising service, in those days it was a deputising service, you find out about it two weeks later when they sent you a slip. Unless the patient volunteered it, you didn’t know they’d been seen because there were no… You know, now, I mean, everything comes through on a computer link or with fax or whatever and oh so and so’s been seen. You know, I’m would I have changed my approach having seen her on the Thursday if I’d known about the deputising? I might **have**/. But nevertheless, I’d made that judgement call, you know, I’m satisfied there wasn’t something acute. The fact that Richard has seen her at midnight did not alter what I was going to do on the Friday morning because she was, you know, she’s very poorly **anyway**/. Harrowing, because she’s sitting there and going, well, you know, you were **there**/… and but what was comforting, if you like, was the unequivocal support I had from the husband who was, you know, just lost his wife and you turn around and said, no, don’t have a go at the doctor; no, I’m not doing that, you know there was almost an argument across the front of me **because**/… And I thought, well, you know, one of the things I’ve always done, not necessarily as a consequence of that, is you can’t duck behind the parapet. One of the biggest criticisms of medical sort of mistakes is that the person that allegedly has made a mistake hides behind something. I think in practise, one of things you've got to do is to face up the reality of **it**/. You know, if there's something that's going on, go and face it down because you won the respect for your openness and secondly if you are going to get a complaint, you've got a good idea whether it’s coming or **not**/. I mean, I can then think of another case where there was a diagnosis of cancer and I went to have a chat to them after the diagnosis. I mean the lady who got the diagnosis was a cancer-phob, she fears everything with cancer. But the way we have to manage and say, “Forget about her thoughts, what's going on you,” and the husband turned around and said, oh, thank you very much for coming. We’re going to change practise but, you know, you've come down into a lion's den, was his phrase and I said, well, you deserve to have answers, all I can do is tell you what I thought at the time and how this rolled **out**/. So similarly, I was talking registrars, you know, if there's going to be an issue, running away from it isn't going to stop that coming, in fact it’ll do the opposite, then you’ll get even more hurt and more dissatisfied. If you go in and you stand up and you face down whatever music it might be, then you’re going to be in a much stronger position, both because you’ve laid to rest that challenge and the people who have spent… you know, the moral courage to go and say, you know, yes I made a mistake, I didn't see that coming or **wheteve**r/. Yeah, yeah. Well, I went to see him on the **Monday**/. Yeah, it must have. I think I would have been certainly much more defensive probably in the way that I would approach things. I mean the beauty about the practise I worked in, and Sue worked for years with us, is that we worked as a practise. We weren’t, we weren’t, we didn’t have individual lists, we’re always prepared to, to, to talk about things. I mean, as I said, Ian was enormously supportive so in some ways, if I got anything that I was unsure about, I’d bounce it around, like what do you think, would you go and see so and so, what do you think this might be? So, it came out in the wash in many **ways**/. I mean the raking of the coals two or three years later with her sister was emm bizarre. It was freakish really, you know, to be in a situation and thinking, oh my god I'm meeting her sister now, and I know what's going on here now, and she's not going to—she's going to turn, you know? But that was very interesting when she came to see me afterwards, you know, and talked about a cathartic experience, for both of **us**/. And I think, I always used to—well, you know, one of the things I used to pride myself on was that I would always look at things as openly as I possibly could, I never prejudge **it**/. And I think, that became one of my watchwords to my practise and certainly in teaching registrars, is don't take yourself down in a blind alley, you always work with a broad sheet. You can narrow it down, well after you've done it, but never discount the differential. Because I mean in this situation, I mean the differential… Okay, it could have been appendicitis, it could have been [inaudible], it could have urinary tract infection, it could have been appendicitis, it could have been a carcinoma, unfortunately she had the worst thing because she has tubo-ovarian abscess and it **ruptured**/. Well, I think I had my psychological support from within the practise and without the practise. You know, in some ways I went looking for answers because I knew that I couldn't deal with this unless I knew what had **happened**/. And the clinicians that supplied the answers from secondary care were hugely supportive, so that helped. And then within practise, you know, both Ian and John were excellent **really**/. So, in some ways, there was a psychological support, not a structured one or anything like that, but the fact that we're all in this together, you know? If you end up working in a practise where your partners are ducking and weaving from shared collective responsibility, if you like, then it's a difficult practise. I mean, obviously, as individuals, you make decisions and the buck stops with you, but if something kicks off in the practise then the one thing, we sort of four square together. You know, this is a practise situation, you know, I can't think of a situation where there were other sort of “misdiagnosis” which are inevitable in any practise where, you know, the other two of us then supported that individual who turn around and say, you know, there but for the grace of God **go I**/. Well, it helps in the sense that you turn around and go, you know, I couldn't have seen that coming… You know, going back to my comment about her saying she was menstruating, I mean what happened then is because she got this festering abscess as well and was menstruating, the reason she ended up with DIC is that she was just continuing **losing**/. And, you know, the sequence of events, you know, as almost everything in medicine, it’s not one thing. It’s a series of, of events sort of accumulative until such point as the straw breaks the camel’s back rather than… You know, almost without exception, I can't think I have seen anything where there's been a medical mishap – if I can phrase that way – where there’s been one single action, it’s often a sequence **thing**/. I mean, one of the things we always used to do in practise when we made an impactful diagnosis was, right, read the notes backward. So now you know what it is. Let's go back to the note and see where, you know, this is, you know one of the things that we always did and I'm not so sure we did it just because of what I've gone through, but we always would put a microscope to things where we think, well, where that come from? Let's have a **look**/. So, we were doing significant event analyses as a group long before they started saying we should be doing this. I mean, we would—because the two practises we had a meeting on a Friday, one of us should present like, oh my god where did this come **from?** / So, we share the experiences and I'm sure I will have probably done that—I can't I can't remember now but I'm sure I would have looked around and said, you know, look at this, learn from what happened to me. And that, I mean, that’s a tool, if you like, of right, now you know what the diagnosis is, now work it back and see whether there's a point, an earlier point in time that you could have with the benefit of hindsight spotted **it**/. And, you know, often you say to people, “Okay…” when we’re teaching the registrars, “Right, okay, we present that, what’s the worst-case diagnosis at this point or that?” “Right, work on that, now let's see if the pieces fit into the **jigsaw**. /” Because unless you sometimes—you're always thinking prospectively, sometimes you need to turn and say, okay, let’s imagine it goes to that and think about it retrospectively, does it fit? And it's amazing how you sometimes turn up things and go, right, we go looking now… because flipping it around and looking it from the other side, suddenly you’ve pieces of the jigsaw that you can’t get to fit suddenly start **fitting**/. So, I think in many ways, an experience like that, particularly early in the general practise career, it teaches you never to assume anything. Always have that sort of degree of scepticism, and certainly a degree of clinical awareness where you turn around and say, okay, I’m working on that thing but there are other things I need to keep my mind open about. I think, I mean, how did it **come**/. I wouldn't say I was more cautious but never underestimate the sort of ability of a condition to take you by surprise. You know, common things are common but the uncommon presentation of the common thing is something that sometimes take—you know, you always got to be sitting there going, what if, could it, and just keep on asking yourself **questions**/. And part of that is that sort of approach to things gives you clinical satisfaction, you know, you’ll end up hopefully spotting things that might have gone by if you haven't done it that way and feeling that you’d done the decent day’s **work**/.

Appendix D: example analysis from meaning units to constituents

George Analysis (All names including place names have been changed for confidentiality)

Constituent Key

Colour code	Constituent
⬜	**Constituent 1: The unfolding of events leading up to the SI**
🟧	**Constituent 2: The awakening awareness of the error.**
🟨	**Constituent 3: Searching the debris of the SI for answers, using the retrospectoscope.**
🟩	**Constituent 4: The professional existential dread of being involved in a SI.**
🟪	**Constituent 5: Letting down those who trusted me with their lives**
🟦	**Constituent 6: “You’ve got to hold it together”**
🟥	**Constituent 7: The experience of helpful and unhelpful others**
⬜	**Constituent 8: The psychological impact on participants’ future practice**
🟫	**Constituent 9: Psychological support: not considered, but would have been if offered as part of the process**

MU	Raw Transcript Data	Third Person Transcript	Meaning Unit 1st Transformation	Meaning Unit 2nd Transformation
0	and often you then feel a bit humbled by the trust they put in you and similarly, you want to make sure you don't abuse that trust and let them down. (line 68 p. 3)	George feels humbled that his patients trust him. George wants to make sure that he doesn’t abuse that trust and let them down.	For George the trust his patients has in him is important. The potential to abuse that trust and let them down is very real	
1	Well, it was a July day, a Thursday afternoon where we used to shut the surgeries on Thursdays and—well,	Well, it was a July day, a Thursday afternoon in July, the surgery where George worked was on a half day closing. All of the doctors were still	On the day in question, George was on call. George received a call about a patient in her mid-forties with abdominal pain	George was solely responsible for any patient who required an on-call doctor

	Thursday afternoons, it was the days when it was half day closing but one of us to be on-call and I was I was in the—well, we're on-call, we were always in the building and I got a call late on a, on a Thursday evening to go and see a lady who was mid 40s with abdominal pain	in the building doing other work. George was on call and later in the evening received a call regarding a lady in her mid-forties who had abdominal pain.		
2	and what I hadn't realised which was perhaps relevant	At that point George was unaware that the lady had been previously seen	George stated that the patient had been seen previously by his colleagues but he	George did not have all of the recent doctor visit information for this patient and

	afterwards is she'd been seen twice. My, my, my partner, John, had spoken to her and she'd been seen by the out of hours on the Tuesday.	twice, by George's surgery partner and the out-of- hours doctor the previous Tuesday	was unaware of this	therefore did not know what the previous doctors had thought about the patient
3	So, this was a sunny July, Thursday afternoon, and she was in a bedroom, emmm. I, emm, I don't know if I'd met her before, a lovely lady, eh, but I met her husband before a lovely lady, eh, but I met her	The day was a sunny July Thursday afternoon and the lady was in a bedroom. George couldn't recall if he had met her before but thought she was a lovely lady and he had met her husband before a lovely lady, eh, but I met her husband	George recalled that the day was very sunny. He went to the home of the patient where he found her in her in her bedroom. He recalled meeting the patient's husband but was unsure if he met the patient previously.	

	husband before emm complaining of lower abdominal pain	before emm complaining of lower abdominal pain		
4	I thought it was, I thought it was probably a urinary tract infection. I examined her, she hadn't got any localising sort of surgical signs, emmm. Tested the urine, it was quite heavily stained with blood but she volunteered that she was menstruating. Emm I thought she'd probably	George thought the lady probably had a urinary tract infection. He examined her and he found that she hadn't got any localising sort of surgical signs. George tested her urine which he found was quite heavily stained with blood but the lady volunteered that she was menstruating. George thought she'd probably got a urinary tract	George found blood in the patient's urine, but the patient said she was menstruating. He thought that she probably had a urinary tract infection and so he gave her antibiotics. He then left the patient's home	George was confident about the patient's condition. He had a reasonable explanation for the appearance of blood in urine and he gave her treatment and left

	got a urinary tract infection and in those days, we carried emmm starter packs of antibiotics, I gave her the starter pack, gave her a prescription, left her that and I said okay, you know, let's see how things roll	infection and, George said, in those days, he carried starter packs of antibiotics, he gave her the starter pack, gave her a prescription, left her that and then said okay, let's see how things roll		
5	The following morning then, there was another call, I thought oh what's going on there, so I rang, her husband she'd been really poorly	The following morning, George said there was another call, George said he thought oh what's going on there and rang, the lady's husband who said she'd	The next day George discovered the patient's husband had called again. He wondered at this point what was going on. He spoke to the patient's husband	

	overnight, she was seen by the out of hours at midnight, emmm, can you come and have another look at her? And I said there's no problem, I mean, there was no emm friction in terms of, you know, turning down, refusing to house calls or anything like that	been really poorly overnight, the husband told George she was seen by the out of hours at midnight and then asked if he could come and have another look at her. George told the husband that there was no problem. George stated that there was no friction in terms of turning down, refusing to house calls or anything like that.	and found that another doctor had been in during the night. George agreed to come and see the patient	
6	And then I recall most about it is I went in and she was in a different	The most that George said he recalled about it was when he went in and she	George recalled that the first thing he noticed was that the patient was in a different	George becomes aware that there is something other than what he first thought

	bedroom and she was in a—she'd been in her own bedroom, I think, the night before and she was in her son's bedroom which was very, very blue, blue curtains so that the lighting in the room was blue. And I went in and said, "Oh…" Jane is her name, I said "Hey Jane, what's up?" and all I did was put my hand on her tum, and she gasped…I	was in a different bedroom from her own bedroom. George stated that he thought that the night before she was now in her son's bedroom which was very, very blue, blue curtains so that the lighting in the room was blue. George said he went in and said, [to the lady] "Hey Jane, what's up?" and all George did was put his hand on her tum, and she gasped…George stated that he thought there's something	room, a very blue room with blue curtains that with the sun shining through coloured everything, including the patient blue. When George put his hand upon the patient's abdomen she gasped and at this moment that George realised that something other than what he originally thought was happening. He then thought that perhaps she had acute appendicitis. He recalls ringing the	happening to the patient. He thinks of a second diagnoses and tells the hospital.

	thought, oh she's, there's something definitely going on here and I thought that she probably got an acute appendicitis. So, I remember ringing, ringing the eh, the, the on-call surgical team and say I think it's [inaudible] and they say, fine	definitely going on here and he thought that she probably had an acute appendicitis. He stated that he remembered ringing the on-call surgical team and say I think its appendicitis and he said they said fine,	hospital to tell them he thought she had appendicitis.	
7	So, I was sitting there thinking I'm missing something here	George said that he was sitting there and thinking he had missed something here	George recalls sitting down and thinking that he had missed something	George is intuiting that there is something he has missed and he has sat to think about what it could be

8	and then I went in and thought, right, yeah you know, blue, open the curtains and she was still blue. Oh god, what's going on here? So then—because all the time we'd been really, you know, I had made the assessment the night before, this is building on, I went in and there's much more going on here, do a blood pressure and blood pressures	Then George went in and he said he thought, "right, yeah you know, blue, open the curtains and found that she was still blue. George said he thought "Oh god, what's going on here?" George said that because he had made the assessment the night before, he had been building on it. George said he went in and thought that there was much more going on, he decided to do a blood pressure and the blood	George went into the patient's room and opened the curtains, the patient remained blue. George was shocked and was unable to understand what was happening to the patient. George said that he had been building his assessment of the patient from the previous night and had been following the progression of the condition he believed she had, but he realised in this moment there was much	George reported that he had not been able to see how ill the patient was until he pulled back the curtains and he was shocked to see that her skin was blue. George had been convinced of his initial assessment and the diagnoses he had been building from it, but his patient's new symptoms meant they had not been enough, there was more going on. When George took her blood pressure it

	were in her boots I'm thinking, oh Christ, you know, she's she's got sepsis, whatever	pressures were in her boots. He thought that she had sepsis, whatever.	more than he thought going on. George found that the patient's blood pressure was seriously low. He thought she might have sepsis	was clear that she was seriously ill. George thought of a third more serious diagnosis
9	On those days, we carried— well, I carried, like giving sets of fluids and all sorts of stuff, an ambulance service and we were talking about 1989, July 1989, you know, the ambulance service was very much scoot and shoot, you	George said that in those days they carried sets of fluids and other medical products, the ambulance service in about July 1989, was very much scoot and shoot, there wasn't really paramedics. George was also working at the hospital doing casualty sessions	George followed the maintenance treatment for sepsis and gave the patient fluids. This was to prepare the patient for emergency transportation to hospital, aware that (in those days) the ambulance crew were not able to do this. George	

	didn't really have paramedics. So, I—I and I was still doing casualty sessions so emmm, I've got a bag of saline and line and put a line up, rang the am… 999 I think then the ambulance service had just arranged this … can you do this now as an immediate, and in fairness to them they responded very quickly. Emmm, actually wrapped her in	at that time. George got a bag of saline and put a line up, he rang 999 and asked if they could do this now as an immediate, and they responded very quickly. George wrapped the lady in a space blanket to try and maintain things, with her legs up. Got her in to M Hospital	accompanied the patient to the hospital, maintaining her condition on the way.	

	a space blanket to try and maintain things, legs up. Got her in to M Hospital			
10	emmm at that stage I wasn't at all sure what had going on	At that stage George wasn't sure what was going on	George did not know what was happening to the patient	
11	it turned out that she'd got a tubo-ovarian abscess on the right-hand side which is why I was thinking appendicitis. Emmm, unfortunately, the, because she was menstruating, she continued to bleed, they	George stated that the next day he found out that the lady had got a tubo-ovarian abscess on the right-hand side which is why he thought of appendicitis. George stated that unfortunately, because she was menstruating, she continued to	The next day George discovered that the patient had bled out on the operating table	George finds out that the patient has died, he describes the process of her decline and why the surgeons were unable to save her. From the information he has been given he finds a rationale for why he made one of

	took her to theatre trying to, tried to emmm control things by eh giving her hysterectomy [participant visibly upset] but unfortunately, she died on the table from something called a DIC which is disseminated intravascular coagulation where you lose all your clotting products, she simply bled to death	bleed, they took her to theatre, tried to control things by giving her a hysterectomy [participant visibly upset] but unfortunately, she died on the table from something called a DIC which is disseminated intravascular coagulation where you lose all your clotting products, she simply bled to death		his diagnoses, albeit not correct
12	So emm I heard about—I can't	George couldn't remember how he	George can't remember how	George has no memory of how

	remember how I heard, I think I might have run that but anyway, the short and tall of it is I had a very emotional morning on the Sunday, because she passed away on the Sunday, and John, my senior partner and I went for a drink and I was probably mmm [participant pauses and is tearful] this close to packing in as a [inaudible] [participant	heard what had happened. He thought he might have rung. He said the short and tall of it was that he had a very emotional morning on the Sunday, because she passed away on the Sunday, and John, George's and his senior partner went for a drink and he said he was probably [participant pauses and is tearful] this close to packing in as a [inaudible] [participant	he found out what had happened, but he remembers being very emotional upon hearing the news. He went for a drink with his senior partner and recalls coming close to leaving medicine	his patient died. George was very emotional at the loss of his patient, at that point he wanted to give up medicine

	tearful, visibly upset].	tearful, visibly upset].		
13	And it was, you know, you're back to the sort of emotional sort of attachment you have to your patients you're sitting there going, oh, you know, where did this come from?	George said it was back to the sort of emotional sort of attachment he has to his patients he said he's sitting there going, oh, you know, where did this come from?	George described his distress as coming from the sense of emotional attachment he has with his patients and the experience of the loss of one of them and not knowing where it came from	George did not know that the patient was seriously ill. For George, he feels an attachment to his patients and so for one to die and that attachment to be broken without him knowing where it came from, was meaningful to him
14	So, I thought, well, I've got to go and see, see them, so I went on the Monday morning to see them and Michael was	George thought that he had to go and see them so he went on the Monday morning to see them and Michael [the husband] was	George felt he had to go to see the patient's family. The husband was fine with him but the patient's sister was angry	

	fine, her husband. But his sister-in-law, her sister was gunning for me.	fine. But his sister-in-law, her sister was gunning for George.		
15	And so I then had a chat with him about how things have rolled out and explored a little bit further and realised that, not only is she had a contact with John on the Monday or Tuesday, she'd seen the out of hours doctor on the Wednesday which I didn't know anything about, and then also it seemed	George then had a chat with him about how things have rolled out and explored a little bit further and realised that, not only that she had contact with John on the Monday or Tuesday, she'd seen the out of hours doctor on the Wednesday which George didn't know anything about, and then also it seemed one of	George spoke with the patient’s husband about what happened. George explored further with the husband and discovered that the patient had been seen by a number of other doctors prior to his initial visit. George rang one of the doctors who had seen the patient, in an attempt to discover if they had noticed	George went to see the patient’s husband both to discuss with him what happened to the patient in the hospital but also George starts the journey to try to discover anything that he didn’t know. At this point George discovered the patient had been seen by a number of other doctors. George telephoned one of those doctors

	one of my colleagues on another one out of hours on midnight on the Thursday who in fact I knew very well who's an anaesthetist and GP, so I rang him and said, you know, did anything seem out of the ordinary.	George's colleagues on another one out of hours on midnight on the Thursday who in fact George knew very well, who's an anaesthetist and GP, so George rang him and said, did anything seem out of the ordinary.	anything out of the ordinary that George hadn't	to discover if they had seen something that George had missed.
16	And going back to the reason why she changed rooms is she had diarrhoea, so she'd soiled the bed in the other bedroom, which	George said that going back to the reason why she changed rooms was that she had diarrhoea, so she'd soiled the bed in the other bedroom	George explained that the patient had been in the blue room (where he had been unaware that her blue colour was from her deteriorating condition, rather	

	is why, you know?		than the sun through the curtains) because she had soiled her own bed.	
17	Emmm, and I was, you know, pretty fresh out of hospital then, so I knew all the personalities involved; the, the gynaecologist who operated on her was a guy I'd worked for, the surgeon who'd who'd been involved in it was also a fellow I knew pretty well, the intensivist who looked after her	George said he was pretty fresh out of hospital then, so he knew all the personalities involved; the, the gynaecologist who operated on her was a guy George had worked for, the surgeon who'd, who'd been involved in it was also a fellow George knew pretty well, the intensivist who looked after her	George knew the hospital medical staff well as he had been their colleague and had only just left to be a GP. He had worked for the surgeon and he knew the intensivist from when they were both medical students. George said they were supportive of him and this meant he was able to continue his search for what	George continued to try to find out more about what happened to the patient, from his colleagues he found them to be very supportive

	was a fellow that I'd known from med school, and all of them were very supportive. Because I went when I had a chance and said, you know, what happened, how did this roll out,	was a fellow that he'd known from med school, and George said they were very supportive. George went when he had a chance and said, what happened, how did this roll out	happened to the patient by asking what they thought.	
18	and the paradox about it is I'd probably resuscitated her too well, at home because by the time she got into M Hospital, she's got a blood pressure of 140 systolic	George said that the paradox about it is he'd probably resuscitated the lady too well at home, because by the time she got into M Hospital, she'd got a blood pressure of 140 systolic whereas it'd been in her	George said that resuscitating the patient at home was a paradox	

	whereas it'd been in her boots here but I mean she'd had nearly two litres of fluid because—but the first one happened, squeeze it through and but the second one… by the time the ambulance arrived.	boots at home but George said she'd had nearly two litres of fluid, the first one happened, squeezed it through and but the second one… by the time the ambulance arrived.		
19	. Ehhh, and it rumbled—well, it didn't rumble on, I mean there was no complaint but it was more about how I felt about going through a	George said it rumbled—well, it didn't rumble on, George said he means there was no complaint but it, was more about how George felt about going	George described the rapid, unexpected unfolding of events. Believing the patient had a relatively straightforward	George's experience of what happened to the patient was of a catastrophic explosion of events that he hadn't seen coming and

	process and seeing how something that appeared to be relatively straightforward suddenly exploding into a catastrophe and back to the feeling of knowing the family, there were two teenage children, a boy and a girl, they just had spent a, you know, fortune on extension on the back of the bungalow and all the rest of it. I mean, you	through a process and seeing how something that appeared to be relatively straightforward suddenly exploding into a catastrophe and back to the feeling of knowing the family, there were two teenage children, a boy and a girl, they just had spent a fortune on extension on the back of the bungalow. George stated I mean, you know, their family life was [pause] fine and then	illness, he became no more than the bystander, the spectator as her illness suddenly reared up and explode into catastrophe. He knew the patient's family, he knew intimate details of their family life, he knew her children and he knew they were building their home; their family life was fine but now, suddenly it was absolutely shattered.	because of that, couldn't prevent the patient from dying and the family having everything shattered.

	know, their family life was [pause] fine and then suddenly, this absolutely shattered things	suddenly, this absolutely shattered things.		
20	. And you had got this— Michael said, oh, my sister-in-law says we should complain but I'm perfectly happy what you did, you did everything you could. And I said, you know, you must do what you feel is right for you, I won't think anything, any different about you, if you feel	George stated that you had got this — Michael said, "oh, my sister-in-law says we should complain but I'm perfectly happy what you did, you did everything you could". George said he replied that you must do what you feel is right for you, George told him he won't think anything, any different about	The family are divided, the patient's husband is happy with what George did but her sister wants to complain, the husband tells George this. George tells the patient's husband that if he wants to submit a complaint, he must do what he feels is right and he reassures the husband that	

	you want to do it because, you know, there are questions that need to be answered, emmm but he didn't.	you, if you feel you want to do it because, you know, there are questions that need to be answered, but he didn't.	doing so will not change their relationship. George told the husband there are questions that need answering.	
21	And the really perverse thing about it is probably two, two and a half years later, I had to go and see the sister who had also seen Ian Millington before who diagnosed a urinary tract infection. I went to see her in her home and you	George said that the really perverse thing about it is probably two, two and a half years later, he had to go and see the sister who had also seen John before who diagnosed a urinary tract infection. George went to see her in her home and you can imagine the atmosphere was	George mentioned that two years later the patient's sister was unwell and he went to her on a home visit and found that she had a large pelvic mass. He advised her to go into hospital. This patient indicated that she felt that George would say that and	

	can imagine the atmosphere was quite cold, and I examined her and thought, oh my god, she's got a massive pelvic mass. And I just said, "Well, you need to go into hospital," "oh La, la, la, la," you know, but sort of you would say that wouldn't you and I thought, okay, and I said, "Listen, you know, I know that you have issues about what happened to your sister, I	quite cold, and George examined her and thought, oh my god, she's got a massive pelvic mass. And he just said, "Well, you need to go into hospital," "oh La, la, la, la," you know, but sort of you would say that wouldn't you and George thought, okay, and said, "Listen, you know, I know that you have issues about what happened to your sister, but we're not talking about your sister now, we're talking about you."	George told her that he knew she had issues about what happened with her sister but this occasion was about her. George had difficulty in getting the hospital team to accept her but he insisted. She went to theatre and she almost died because a cancerous cyst ruptured on the theatre table. George said the sister came to see him afterwards and said she was wrong about him.	

	said, but we're not talking about your sister now, we're talking about you." Emm I had some, some significant difficulty in getting the gyne SHO to accept her, but I didn't take no for an answer. I sent her in, she [pause] went to theatre in a couple of days later and she had a massive ovarian cyst that ruptured at as they entered and she nearly	George had some, significant difficulty in getting the gyne SHO [senior house officer] to accept her, but he said he didn't take no for an answer. He sent her in, she went to theatre a couple of days later and she had a massive ovarian cyst that ruptured as they entered and she nearly exsanguinated on the table and she turned out to actually have, an ovarian carcinoma. George said she had the grace to	After that, the sister would come to see George, when she needed a doctor	

	exsanguinated on the table, and she turned out to actually have, emm, an ovarian carcinoma. But she had the grace to come and see me afterwards and say, oh I was wrong about you, you know, and funny enough then sort of always came to see me. Ehhh, she ended up having chemo and then she moved away but she did very well.	come and see him afterwards and say, oh I was wrong about you, you know, and funny enough then sort of always came to see him. George said she ended up having chemo and then she moved away but she did very well.		

22	But it's it's really quite bizarre because it's almost like lightning striking twice, but it gave her an insight into just how things went, how things went completely tee up with her sister. Emmm, [pause] but it took me a very long time to shake it off and I suppose, I become quite, quite defensive for a while. I managed to laugh it off in a way of saying,	George said it took him a *very* long time to shake it off and he supposed, he became quite defensive for a while. He said he managed to laugh it off in a way of saying, "Right, well… you know", he said, "You know, on Friday the 13th, I'm not going to do any clinical work on Friday the 13th" so George said he teaches or takes the day off." He carries on doing that. He said it's just a standing joke really.	George said that it took a very long time to shake off what happened and he felt he practiced quite defensively for a while. He said however, that it is still impacting upon him. He cannot bring himself to undertake clinical work on any Friday 13th (the day the patient died), he will teach or take the day off. As time has passed this has become a standing joke in the practice and he too laughs it	Although George feels that he is no longer defensive in his work, he cannot bring himself to work on Friday 13ths – he is unable to see any patients. It laughs it off but it is still meaningful for him as the date his patient died

	"Right, well…" you know, I said, "You know, on Friday the 13th, I'm not going to do any clinical work on Friday the 13th, so I teach or I take the day off." I carry on doing that. It's just a standing joke really.		off, but still he will not work.	
	Well, I was lucky in the sense that my wife has trained, so she had, you know, an appropriate insight into what I have done	George said he was lucky in the sense that his wife has trained, so she had an appropriate insight into what he had done because, you	His wife is also medical and so understands and has insight into what he had done with the patient, she knows what it is like when things	George's wife has shared experiences of what it is to be a clinician

	because, you know, she worked on surgical wards and she'd seen things go tee up. Emmm, I, so, I'm trying to think in '89, we had… Yeah, I had two sons and Tom was 18 months, Fred was about a month old, you know, so the kids weren't affected by it anyway.	know, she worked on surgical wards and she'd seen things go tee up. George tried to think in '89, they had two sons and Tom was 18 months,Fred was about a month old, you know, so the kids weren't affected by it anyway	go wrong unexpectantly. His children were very young, he doesn't think they were affected by it.	
24	My partners were hugely supportive, [pause] and we worked in a group with	George said his partners were hugely supportive and they worked in a group with another practise	George's colleagues were very supportive. George may have presented the case to his	

	another practise and they were equally supportive. I think I presented, I can't remember, didn't do a formal presentation where we certainly talked about it,	and they were equally supportive. George thinks he presented, he can't remember, he didn't do a formal presentation but they certainly talked about it,	colleagues but he can't remember but he is sure it wasn't done formally	
25	because the first time I come across someone with a DIC emmm— well, no, it wasn't actually, I'd seen one in XXX where again unfortunately she died on the	because the first time George came across someone with a DIC. Then, no, it wasn't actually, George had seen one in M hospital where again unfortunately she died on the table as well, so	George had previous experience of a woman who had had come to the hospital and had the same problem, she also had died on the table	

	table as well, so like I was familiar with that.	George was familiar with that.		
26	Emmm, and I [inaudible] you know, what helped? Undoubtedly, it was the fact that Michael her husband wasn't terribly well himself, he kept on coming to see me, so you know, it was an explicit statement of trust, if you like, which helped enormously. So, in some ways, we had a	George said that undoubtedly what helped was the fact that XXX her husband wasn't terribly well himself, he kept on coming to see George, so you know, it was an explicit statement of trust, if you like, which helped enormously. So, in some ways, we had a shared grieving process.	George said that his patient's husband, who wasn't well himself, still chose to come to see him as his doctor and this undoubtedly helped him. George saw this as the husband making an explicit statement of trust in George as a doctor and this enabled George to feel that they shared the journey of grieving for the	George said that not only did his patient's husband still seeing him demonstrated trust but also enabled George to feel connected to him, in a shared sense of grief and loss

	shared grieving process.		death of the patient.	
27	Well, I think they… I mean, at that stage it was all in the front of my face. I mean, it was afterwards perhaps that the emmm… they, I mean, I remember speaking to John who was the intensivist and David, he qualified the year I started training in medicine so we overlapped quite fleetingly but I mean we	George said that at that stage it was all in the front of my face and that afterwards perhaps that the, George remembered speaking to XXX who was the intensivist and XXX, he qualified the year George started training in medicine so they overlapped quite fleetingly but they played—he'd been the captain of the rugby club and so George got to know him	George said that at this time, the patient's death was in the forefront of his mind. George sought reassurance from his colleagues and clinical friends who had been involved in the patient's care. These people were more than work colleagues, he had trained with them, played rugby with them their lives were intertwined both in work and	What happened to George's patient stayed with him despite George's close colleagues' and friends' reassurances

	played—he'd been the captain of the rugby club [inaudible] and so I got to know him quite well anyway. And his take on it was—I don't know how you guys do it, how do you spot something like this in the community. So, very supportive about the challenge in recognising something at the start of a journey. Emmm Peter emmm the gyne	quite well anyway. And his take on it was George said XXX said "I don't know how you guys do it, how do you spot something like this in the community?". George said they were very supportive about the challenge in recognising something at the start of a journey. XXX emmm the gyne consultant, George worked for him for six months and XXX just said, "Look, these things happen. You	outside of it and George knew them well. They told George that they didn't know how he could spot something like that in the community, that they didn't think he had missed anything, that he had acted on it. They acknowledged the challenge it must have been for George and told him that these things happen. George continued to work with these colleagues	

	consultant, I worked for him for six months and he just said, “Look, these things happen. You know, you didn't miss something, you acted on it.” I mean, in cas [casualty/A&E] I mean I was still doing clinical assistant sessions on a Sunday evening there so I knew all the personalities involved there.	know, you didn't miss something, you acted on it.” In cas [casualty/A&E] George said he was still doing clinical assistant sessions on a Sunday evening there so he knew all the personalities involved there.		

28	I'd redirected the ambulance from taking her to a surgical ward saying, "Look, bring her into cas [casualty/ A&E]," I said, "She needs to be ressussed [resuscitated] we've got to get in to resuss [intensive care] her there." So, I was almost switching roles, you know, I followed the ambulance in and I went into recess. To a certain extent, I acted as a	George stated that he had redirected the ambulance from taking her to a surgical ward saying, "Look, bring her into cas [casualty/ A&E]." He said, "She needs to be ressussed [resuscitated] we've got to get in to resuss [intensive care] her there." So, George was almost switching roles George followed the ambulance in and he went into recuss. To a certain extent,	George had taken control of the situation when the ambulance arrived and had directed it away from taking the patient to a surgical ward to causality instead, because he felt the patient needed resuscitating. George felt that he was switching roles to a handing over clinician. George said that he went through the process of getting the patient to	George felt in control of the situation at that point, he could do that on auto-pilot, he knew what to do

	handing over clinician rather than the ambulance service because in those days, we didn't have paramedics, I mean they were ambulance boys, lovely guys but I remember saying, you know, have you got a space blanket, “What’s a space blanket? No” I said, I got one in the boot of the car, you know, wrap her up in that, like just get her legs	George stated that he acted as a handing over clinician rather than the ambulance service because in those days, they didn't have paramedics, George said they were ambulance boys, lovely guys but George remember saying, have you got a space blanket, George said they replied “What’s a space blanket? No” George said, he’s got one in the boot of his car, you know, wrap her up in that, like	hospital almost on auto-pilot	

	up and so forth. Emmm and so, I went through a lot of that [cough] almost on autopilot,	just get her legs up and so forth. Emmm and so, George stated he went through a lot of that almost on autopilot		
29	and it was only afterwards when things had happened that I went and thought, well, I've got to find some answers here, just find out what happened. Because, you know, instead of going from being someone who left the house with a [pause]	and it was only afterwards when things had happened that George went and thought that he's got to find some answers here, just find out what happened. George said because instead of going from being someone who left the house with a recordable blood pressure and… you know,	George said that it was not until after the patient died that he got to find some answers about what had happened. This was important to him because, for George, he had left the house with a patient who was chatting away, not obviously toxic, but she was, unknown to him,	It was only afterwards that George realised he hadn't been in control or aware of the patient's deteriorating condition. That she was bleeding out while she was talking to him and that she had very little time left alive and he didn't know

	recordable blood pressure and… you know, chatting away, she wasn't, she wasn't ill, it wasn't something as if she was sitting there and toxic or anything like that, though I [inaudible] with my first thing was, you know, was this sepsis, but it was actually hypovolemic, you know, she was exsanguinating until this thing had ruptured	chatting away, she wasn't, she wasn't ill, it wasn't something as if she was sitting there and toxic or anything like that, though, with George's first thing was, you know, was this sepsis, but it was actually hypovolemic, she was exsanguinating until this thing had ruptured and the rest of it was— emmm, you know, the rest took its toll, if you like	significantly bleeding and together with the rupture this was too much for her body and she died.	

	and the rest of it was—emmm, you know, the rest took its toll, if you like.			
30	So, it was very much sort of, right, so having someone described what they found, I'm thinking, "Oh right, so that's what it was. Right, okay." And then, you know, I mean it's partly the differential… I mean as a general practitioner, you look and turn around and said, "Does this	George said it was very much sort of, right, so having someone described what they found, George thought, "Oh right, so that's what it was. Right, okay." And then George stated that it's partly the differential, as a general practitioner, George said you look and turn around and say, "Does this person	George said that finding what had happened enabled him to understand that his actions on that last day, his final decisions were appropriately based upon whether or not the patient had needed admitting to hospital, the partial differential, rather than the finer points of the differential diagnosis; how ill	George took comfort from knowing that his last decisions were right, that he looked away from diagnosis and instead asked himself instead if the patient needed further help and he made the right choice

	person need to be admitted?” “Yes.” “Okay, well, let’s get that sorted.” We can worry about the finer points of the differential diagnosis; when she's in hospital, you know, she’s got an acute surgical abdomen query cause, you know, and they weren't bickering about whether it was gyne or surgery at that moment	need to be admitted?” “Yes.” “Okay, well, let’s get that sorted.” George state they can worry about the *finer* points of the differential diagnosis; when she's in hospital, you know, she’s got an acute surgical abdomen query cause, you know, and they weren't bickering about whether it was gyne or surgery at that moment.	she was or what was wrong with her, for which there was time later to discover, when the patient was safely in hospital. No one was querying the type of intervention the patient required at that point, it was clear they would operate.	
31	I mean, and that was	George said that was another	George said that another reason	That final decision was

	another reason for going to cas [casualty/A&E] really because saying that, you know, I'm not so sure what the hell's going on here so if she's worked up in cas [casualty/A&E] then we'll have a better idea. So, the three consultants have been involved, all are very supportive.	reason for going to cas [casualty/A&E] really because saying that, you know, he is not so sure what the hell's going on here so if she's worked up [emergency medical assessment] in cas [casualty/A&E] then they'll have a better idea. So, the three consultants have been involved, all are very supportive.	he decided to take the patient to casualty was because he didn't know what was happening to her and he knew that casualty has the equipment and expertise to potentially help her. George said that the casualty doctors there when the patient came in were all supportive of him.	based upon the acceptance that he didn't know what was happening to the patient and that she needed to be in hospital where they had the equipment and expertise to find out
32	Emmm, I can't really think how it rolled on	George can't really think how it rolled on there, he	George can't recall what happened next.	

	there, I mean I know I was—on the Sunday, I just felt like giving up medicine because you just thought like oh my god, you know, someone's died on my watch. I wrote it all down and stuck in the envelope, dated it, sealed it and put it in the drawer. But I wrote everything down because if something happens; I'm not trying to write a narrative	knows know he was—on the Sunday, George said he just felt like giving up medicine because he just thought like oh my god, you know, someone's died on his watch. George wrote it all down and stuck in the envelope, dated it, sealed it and put it in the drawer. But he wrote everything down because if something happens; he's not trying to write a narrative about what happened, with something	He remembers feeling that he wanted to give up medicine because a person had died and he was the doctor caring for them. George wrote down his thoughts about what had happened and kept it. He was worried that something might happen and he didn't want to be in a position where he had to write a narrative with something hanging over him so he wrote it then so that he	

	about what happened, with something hanging over, I thought if I write it now, I write it in the here and now, if something happens, well, I'll just turn around and say, "There's my, there's my thought on this." And it's the only time, touch wood, I ever had to do that in practise where I sat and thinking	hanging over, he thought if he writes it then, he wrote it in the here and now, if something happens, well, George stated he would just turn around and say, "There's my, there's my thought on this." And it's the only time, touch wood, George ever had to do that in practise where he sat and thinking	would be ready to give his thoughts if necessary. It was the only time George felt that something might happen because his patient had died and that he needed to be prepared for that.	
33	And that was mainly because of the, the aggression from	And that was mainly because of the, the aggression from	George thought that something may happen because of how	George thought the patient's sister might complain about

	the sister who was, you know, she was raw, she was emotional, she was angry, and I was then, you know, "There are four bloody doctors who saw her. Four, four, hell of a four," and then, you know, transpired that she'd be… Because we never got handovers from the deputising service, in those days it was a deputising service, you find out about it two	the sister who was, you know, she was raw, she was emotional, she was angry, and George was then, "There are four bloody doctors who saw her. Four, four, hell of a four," and then, you know, transpired that she'd be… Because they never got handovers from the deputising service, in those days it was a deputising service, they find out about it two weeks later when they sent them a	aggressive, raw and angry the patient's sister was with him. Yet, George said, he wasn't the only doctor to have seen the patient four other doctors had seen her but George didn't know because they didn't get informed until the deputising services sent slips about two weeks later. George only could have known if the patient had told him. If George had known that	him, even though other doctors had seen her. Had the patient's family told him that other doctors had been to see the patient, he might have changed his approach but he will never now know

	weeks later when they sent you a slip. Unless the patient volunteered it, you didn't know they'd been seen because there were no… You know, now, I mean, everything comes through on a computer link or with fax or whatever and oh so and so's been seen. You know, I'm would I have changed my approach having seen her on the Thursday if I'd known	slip. Unless the patient volunteered it, they didn't know they'd been seen because there were no… You know, now, George stated everything comes through on a computer link or with fax or whatever and oh so and so's been seen. George said would he, have changed his approach having seen her on the Thursday if he'd known about the deputising? He might have.	other doctors had seen the patient George thought he may have changed his approach.	

	about the deputising? I might have.			
34	But nevertheless, I'd made that judgement call, you know, I'm satisfied there wasn't something acute. The fact that Richard has seen her at midnight did not alter what I was going to do on the Friday morning because she was, you know, she's very poorly anyway.	But nevertheless, George said he made that judgement call. George is satisfied there wasn't something acute. The fact that XXX has seen her at midnight did not alter what George was going to do on the Friday morning because she was, you know, she's very poorly anyway.	But, George said, it was him who made the judgement call that first night and he thinks there wasn't anything acute at that time and the doctor who saw the patient prior to George on the last night, wouldn't have altered what George did because the patient was critical.	Ultimately it was George alone who made the decisions about the patient

35	Harrowing, because she's sitting there and going, well, you know, you were there…	George said it was harrowing, because she's sitting there and going, well, you know, you were there…	George said that it was harrowing to be sitting with the sister of the patient that died	George described having the patient's sister sitting with him as harrowing and saying that he was the one who was there the last night
36	and but what was comforting, if you like, was the unequivocal support I had from the husband who was, you know, just lost his wife and you turn around and said, no, don't have a go at the doctor; no, I'm not doing that, you know there	and but what was comforting, if you like, was the unequivocal support George had from the husband who was, you know, just lost his wife and you turn around and said, no, don't have a go at the doctor; no, I'm not doing that, you know there was almost	But George said he gained comfort from the support the patient's husband showed him and how he refused to join with his sister in law in admonishing George. And George said he appreciated that he did this, despite having just lost his wife. I	

	was almost an argument across the front of me because…	an argument across the front of me because…	think George blames himself but doesn't explicitly say it	
37	And I thought, well, you know, one of the things I've always done, not necessarily as a consequence of that, is you can't duck behind the parapet. One of the biggest criticisms of medical sort of mistakes is that the person that allegedly has made a mistake hides behind something. I	George thought, well, you know, one of the things he's always done, not necessarily as a consequence of that, is you can't duck behind the parapet. One of the biggest criticisms of medical sort of mistakes is that the person that allegedly has made a mistake hides behind something. George said he thinks in practice,	George said that he faces up to the reality when he makes medical mistakes, he doesn't hide behind anything. George believes that if you face up to mistakes you win respect for openness but also by being open, you know if someone is then going to make a complaint and can be prepared for that	

	think in practise, one of things you've got to do is to face up the reality of it. You know, if there's something that's going on, go and face it down because you won the respect for your openness and secondly if you are going to get a complaint, you've got a good idea whether it's coming or not.	one of things you've got to do is to face up the reality of it. George stated if there's something that's going on, go and face it down because you won the respect for your openness and secondly if you are going to get a complaint, you've got a good idea whether it's coming or not		
38	I mean, I can then think of another case where there was a diagnosis	George said he can then think of another case where there was a diagnosis of	George then gave an example of this and described another patient	

	of cancer and I went to have a chat to them after the diagnosis. I mean the lady who got the diagnosis was a cancer-phob, she fears everything with cancer. But the way we have to manage and say, “Forget about her thoughts, what's going on you,” and the husband turned around and said, oh, thank you very much for coming. We’re going to	cancer and he went to have a chat to them after the diagnosis. George stated that the lady who got the diagnosis was a cancer-phob, she fears everything with cancer. But the way they had to manage and say, “Forget about her thoughts, what's going on you,” and the husband turned around and said, oh, thank you very much for coming. We’re going to change practise but, you know, you've come down into a	who feared cancer but had received a cancer diagnosis. George went to see the patient and although the husband said that they would still change practice, he acknowledged that George had come into a difficult situation and thanked him	

	change practise but, you know, you've come down into a lion's den, was his phrase and I said, well, you deserve to have answers, all I can do is tell you what I thought at the time and how this rolled out.	lion's den, was his phrase and George said, well, you deserve to have answers, all he can do is tell you what he thought at the time and how this rolled out.		
39	So similarly, I was talking registrars, you know, if there's going to be an issue, running away from it isn't going to stop that coming, in fact it'll do the	So similarly, George said he was talking to registrars and said if there's going to be an issue, running away from it isn't going to stop that coming, in fact it'll do the opposite,	George teaches this to junior doctors. He advises that running away will ultimately hurt them more than standing their ground, because it would put them in a stronger	George teaches his students how facing up to their mistakes, demonstrating to themselves that they are able to meet a challenge and to others that they have moral courage

	opposite, then you'll get even more hurt and more dissatisfied. If you go in and you stand up and you face down whatever music it might be, then you're going to be in a much stronger position, both because you've laid to rest that challenge and the people who have spent… you know, the moral courage to go and say, you know, yes I made a mistake, I didn't	then you'll get even more hurt and more dissatisfied. George told the registrars, if you go in and you stand up and you face down whatever music it might be, then you're going to be in a much stronger position, both because you've laid to rest that challenge and the people who have spent the moral courage to go and say, you know, yes they made a mistake, they didn't see	position. George advises that this benefits a doctor within and without, in that they will have put a challenge to rest and demonstrated moral courage in saying they made a mistake, they didn't see it coming.	ultimately makes them stronger people

	see that coming or whatever.	that coming or whatever.		
40	Yeah, yeah. Well, I went to see him on the Monday.	George said he went to see the husband on the Monday.	George went to see the husband Monday	
41	Yeah, it must have. I think I would have been certainly much more defensive probably in the way that I would approach things. I mean the beauty about the practise I worked in, and Sue worked for years with us, is that we worked	George stated he thought he would have been certainly much more defensive probably in the way that he would approach things. He stated that the beauty about the practise he worked in, and XXX worked for years with them, is that we worked as a practise. We weren't, we	George said he would have been more defensive in his work if he hadn't had the support from his colleagues that he did. They worked as a collegiate practice rather than having individual lists. Their normal practice was to talk to each other about cases and	

	as a practise. We weren't, we weren't, we didn't have individual lists, we're always prepared to, to, to talk about things. I mean, as I said, Ian was enormously supportive so in some ways, if I got anything that I was unsure about, I'd bounce it around, like what do you think, would you go and see so and so, what do you think this might be? So, it came out in the	weren't, we didn't have individual lists, we're always prepared to, to, to talk about things. George said that Ian was enormously supportive so in some ways, if George got anything that he was unsure about, he'd bounce it around, like what do you think, would you go and see so and so, what do you think this might be? So, it came out in the wash in many ways.	his senior in the practice was especially supportive and he felt able to ask him what he thought something might be.	

	wash in many ways.			
42	I mean the raking of the coals two or three years later with her sister was emm bizarre. It was freakish really, you know, to be in a situation and thinking, oh my god I'm meeting her sister now, and I know what's going on here now, and she's not going to—she's going to	George stated that the raking of the coals two or three years later with her sister was bizarre. It was freakish really, to George to be in a situation and thinking, "oh my god I'm meeting her sister now, and I know what's going on here now, and she's not going to—she's going to turn, you know?" But George said it	George said that he thought the sister of the patient who died presenting with a similar illness years later was bizarre and freakish. He said that he thought she might turn on him but he said that it had been cathartic for both of them to come together again, as patient and doctor. George prides himself of	

	turn, you know? But that was very interesting when she came to see me afterwards, you know, and talked about a cathartic experience, for both of us. And I think, I always used to—well, you know, one of the things I used to pride myself on was that I would always look at things as openly as I possibly could, I never prejudge it.	was very interesting when she came to see him afterwards, you know, and talked about a cathartic experience, for both of them. And George thinks he always used to—well, you know, one of the things he used to pride himself on was that he would always look at things as openly as he possibly could, he never prejudges it.	not prejudging and always looking at things openly	

43	And I think, that became one of my watchwords to my practise and certainly in teaching registrars, is don't take yourself down in a blind alley, you always work with a broad sheet. You can narrow it down, well after you've done it, but never discount the differential. Because I mean in this situation, I mean the differential… Okay, it could have been	And George thinks, that became one of his watchwords to his practise and certainly in teaching registrars, is don't take yourself down in a blind alley, you always work with a broad sheet. You can narrow it down, well after you've done it, but never discount the differential. Because George said in this situation, the differential… Okay, it could have been appendicitis, it	George teaches his student registrars that the finer details of a patient's condition can be looked at later and that, if they are unsure what is happening for the patients, it is better to consider many different possible diagnoses, the differentials. George refers to the patient who died, stating that it could well have been one of the few conditions he had considered but he had not considered the	After his patient died, George taught doctor's junior to him not to try to look for a definitive diagnosis but to look at the patient's symptoms in broad terms, including all possible causes, rather than a limited number in order to capture as many eventualities as possible

	appendicitis, it could have been [inaudible], it could have urinary tract infection, it could have been appendicitis, it could have been a carcinoma, unfortunately she had the worst thing because she has tubo-ovarian abscess and it ruptured.	could have been [inaudible], it could have urinary tract infection, it could have been appendicitis, it could have been a carcinoma, unfortunately she had the worst thing because she has tubo-ovarian abscess and it ruptured.	broader differential diagnosis and the patient had the worst thing	
44	Well, I think I had my psychological support from	George thinks he had his psychological support from	George feels that his practice provides him with psychological	George sees the support that his colleagues gave him as

	within the practise and without the practise. You know, in some ways I went looking for answers because I knew that I couldn't deal with this unless I knew what had happened.	within the practise and without the practise. You know, he said in some ways he went looking for answers because he knew that he couldn't deal with this unless he knew what had happened.	support but he acknowledges that, nonetheless, without seeking answers to what had happened, he couldn't have dealt with it	psychologically supportive. However, without being able to understand what and how his patient came to die, he would not have been able to deal with it
45	. And the clinicians that supplied the answers from secondary care were hugely supportive, so that helped. And then within practise, you know, both Ian	And the clinicians that supplied the answers from secondary care were hugely supportive, so that helped. And then within practise, you know, both XXX and XXX	Those who provided George with the answers, the hospital clinicians, George feels were hugely supportive	

	and John were excellent really.	were excellent really.		
46	So, in some ways, there was a psychological support, not a structured one or anything like that, but the fact that we're all in this together, you know? If you end up working in a practise where your partners are ducking and weaving from shared collective responsibility, if you like, then it's a difficult practise. I mean,	George stated that in some ways, there was a psychological support, not a structured one or anything like that, but the fact that they were all in this together, you know? If you end up working in a practise where your partners are ducking and weaving from shared collective responsibility, if you like, then it's a difficult practise. George stated that obviously, as individuals, you	The perception of being in a cohesive practice that share responsibility and support each other is psychological support to George. George said that If his practice wasn't so supportive, and there was avoidance of collective responsibility, it would be difficult. George stated that there are still personal decisions and responsibilities,	

	obviously, as individuals, you make decisions and the buck stops with you, but if something kicks off in the practise then the one thing, we sort of four square together. You know, this is a practise situation, you know, I can't think of a situation where there were other sort of "misdiagnosis" which are inevitable in any practise where, you know, the other two of us	make decisions and the buck stops with you, but if something kicks off in the practise then the one thing, they sort of four square together. You know, this is a practise situation, you know, George can't think of a situation where there were other sort of "misdiagnosis" which are inevitable in any practise where, you know, the other two of us then supported that individual who turn around	but if something happens to one of them, they all come together.	

	then supported that individual who turn around and say, you know, there but for the grace of God go I.	and say, you know, there but for the grace of God go I.		
47	Well, it helps in the sense that you turn around and go, you know, I couldn't have seen that coming… You know, going back to my comment about her saying she was menstruating, I mean what	George said that it helps in the sense that you turn around and go, you know, he couldn't have seen that coming… You know, going back to my comment about her saying she was menstruating, what happened	George identifies the point that he couldn't have known that his patient was bleeding out, the point of error. That he can see how, with his patient menstruating masking the true nature of her blood loss	

	happened then is because she got this festering abscess as well and was menstruating, the reason she ended up with DIC is that she was just continuing losing.	then is because she got this festering abscess as well and was menstruating, the reason she ended up with DIC is that she was just continuing losing.		
48	And, you know, the sequence of events, you know, as almost everything in medicine, it's not one thing. It's a series of, of events sort of accumulative until such point as the straw	George said you know, the sequence of events, you know, as almost everything in medicine, it's not one thing. It's a series of, of events sort of accumulative until such point as the	George discussed the sequence of events that is present in all of medicine and how these events can accumulate, if unchecked, until catastrophe occurs. George couldn't think of a	

	breaks the camel’s back rather than… You know, almost without exception, I can't think I have seen anything where there's been a medical mishap – if I can phrase that way – where there’s been one single action, it’s often a sequence thing.	straw breaks the camel’s back rather than… You know, almost without exception, George couldn’t think that he has seen anything where there's been a medical mishap where there’s been one single action, it’s often a sequence thing.	single medical mistake that involved one single action; error is a process.	
49	I mean, one of the things we always used to do in practise when we made an impactful diagnosis was,	George said, one of the things they always used to do in practise when we made an impactful diagnosis was,	Since the incident George, if he makes an impactful diagnosis, traces the process backwards, in	George has changed his practice since his patient died, he examines the process of the patient’s illness

	right, read the notes backward. So now you know what it is. Let's go back to the note and see where, you know, this is, you know one of the things that we always did and I'm not so sure we did it just because of what I've gone through, but we always would put a microscope to things where we think, well, where that come from? Let's have a look.	right, read the notes backward. So now you know what it is. George stated he says let's go back to the note and see where, you know, this is, you know one of the things that we always did and he's not so sure they did it just because of what he's gone through, but they always would put a microscope to things where they think, well, where that come from? Let's have a look.	order to understand the moment when it came, he put a microscope to the journey of the error, so he can know what it is.	progression in detail

50	So, we were doing significant event analyses as a group long before they started saying we should be doing this. I mean, we would—because the two practises we had a meeting on a Friday, one of us should present like, oh my god where did this come from?	So, George stated that when they were doing significant event analyses as a group long before they started saying we should be doing this. George said they we would—because the two practises they had a meeting on a Friday, one of us should present like, oh my god where did this come from?	They would do this collectively, wonder over it and seek to know, where did this come from?	
51	So, we share the experiences and I'm sure I will have probably done that—I can't I	So, George said they share the experiences and he said he is sure he will have probably done	George said in sharing the experiences, in inviting others to learn from what happened to him	George shares his experience in order that others will learn from him

	can't remember now but I'm sure I would have looked around and said, you know, look at this, learn from what happened to me. And that, I mean, that's a tool, if you like, of right, now you know what the diagnosis is, now work it back and see whether there's a point, an earlier point in time that you could have with the benefit of hindsight spotted it.	that—he said he can't remember now but he's sure he would have looked around and said, you know, look at this, learn from what happened to me. And that, George said that's a tool, if you like, of right, now you know what the diagnosis is, now work it back and see whether there's a point, an earlier point in time that you could have with the benefit of hindsight spotted it.	he has learned to look beyond the moment of error to a point in time where, with the gift of hindsight, it could have been avoided. He uses this as a tool	

52	And, you know, often you say to people, “Okay…” when we’re teaching the registrars, “Right, okay, we present that, what’s the worst-case diagnosis at this point or that?” “Right, work on that, now let's see if the pieces fit into the jigsaw.”	And, George said, often you say to people, “Okay…” when they’re teaching the registrars, “Right, okay, they present that, what’s the worst-case diagnosis at this point or that?” “Right, work on that, now let's see if the pieces fit into the jigsaw.”	George often tells his student registrars to first identify the worst case scenario, as the most vital piece in the jigsaw and then fit the rest around it	
53	.” Because unless you sometimes—you're always thinking prospectively, sometimes you need to turn and	Because George stated, unless you sometimes—you're always thinking prospectively, sometimes you need to turn and	George states that he now thinks prospectively, scanning the pieces of possibility from every angle and	George is now acutely vigilant with patients in order to ensure he has accounted for anything that might be hiding out of sight

	say, okay, let's imagine it goes to that and think about it retrospectively, does it fit? And it's amazing how you sometimes turn up things and go, right, we go looking now… because flipping it around and looking it from the other side, suddenly you've pieces of the jigsaw that you can't get to fit suddenly start fitting	say, okay, let's imagine it goes to that and think about it retrospectively, does it fit? And George stated that it's amazing how you sometimes turn up things and go, right, we go looking now… because flipping it around and looking it from the other side, suddenly you've pieces of the jigsaw that you can't get to fit suddenly start fitting.	often he finds things by looking at it from the other side and he finds the piece of the jigsaw that he has been missing	
54	So, I think in many ways, an	So, George said he thinks in many	The patient that died taught	George has learnt from his

	experience like that, particularly early in the general practise career, it teaches you never to assume anything. Always have that sort of degree of scepticism, and certainly a degree of clinical awareness where you turn around and say, okay, I'm working on that thing but there are other things I need to keep my mind open	ways, an experience like that, particularly early in the general practise career, it teaches you never to assume anything. Always have that sort of degree of scepticism, and certainly a degree of clinical awareness where you turn around and George said okay, he's working on that thing but there are other things he needs to keep his mind open about. He thinks, how did it come	George that in order to be able to see the full visa of the jigsaw that is medicine he must never assume anything; he must uphold scepticism and have enough clinical awareness to know to turn around often and look with an open mind because something might be coming.	error; he doesn't take anything for granted and is always prepares. George always thinks, how did it come.

	about. I think, I mean, how did it come			
55	I wouldn't say I was more cautious but never underestimate the sort of ability of a condition to take you by surprise. You know, common things are common but the uncommon presentation of the common thing is something that sometimes take—you know, you always got to be sitting there	George said he wouldn't say he was more cautious but never underestimate the sort of ability of a condition to take you by surprise. You know, common things are common but the uncommon presentation of the common thing is something that sometimes take—you know, you always got to be sitting there going, what if, could it, and just keep on	George wouldn’t describe his medical approach as cautious but instead he describes a vigilance against the element of surprise and says he does not underestimate the ability for uncommon things to masquerade as common and he always asks himself, “what if, could it?”	

	going, what if, could it, and just keep on asking yourself questions.	asking yourself questions.		
56	And part of that is that sort of approach to things gives you clinical satisfaction, you know, you'll end up hopefully spotting things that might have gone by if you haven't done it that way and feeling that you'd done the decent day's work.	And part of that is that sort of approach to things gives you clinical satisfaction, you know, you'll end up hopefully spotting things that might have gone by if you haven't done it that way and feeling that you'd done the decent day's work.	George said the satisfaction of this is having the ability to identify important things that may have brought catastrophe had he not taken this approach, it feels, George said, like a decent day's work.	

Appendix E Table of Participants and their Constituents

	George	Julie	Heather	Laura	Pamela	Simon	Sophie
C1	X	X		X	X		X
C2	X	X	X	X	X	X	X
C3	X	X	X	X	X	X	X
C4	X	X	X	X	X		X
C5	X	X		X		X	
C6	X	X	X	X	X	X	
C7	X	X	X	X			X
C8	X	X	X	X	X		
C9		X	X	X	X	X	X

Appendix: F Bracketing Reflexivity

I have just provided myself with an example of why bracketing is so important in DPA. I have just finished identifying the constituents and I have surprised myself. I have read the transcripts so many times, I feel as if I know them off by heart. I was convinced that one of the constituents would be ‘teaching others’ – but it wasn’t there. A couple of my participants referred to telling students about their experiences but it wasn’t anywhere near strong enough to make a constituent. I was quite confused because, once I had applied bracketing and read through the transcript, it clearly wasn’t there and I wondered where I had got the notion from.

When it came to interviewing my participants, each of them became very distressed when talking about their SIs, they were very difficult interviews for my participants in particular, but also for me. I thought that it was ethical to stay with them after we had finished the interviews, to make sure they were okay. I realised this is where I had got the idea about teaching others from.

As I sat with the participants, each of them told me about what they had thought when I had invited them to take part in the research. They all said that they felt it was important because they wanted medical school students, junior doctors and other young doctors to know that no matter how good they are, SIs can happen. They all took part in the research for the benefit of other doctors. Therefore, ‘teaching others’ wasn’t their experience of their SI, it was my experience of talking to them after I had interviewed them. Without applying bracketing when I was working on the constituents, it could have ended up in my report, which would have distorted the structure of the second victim phenomenon. It was a very worthwhile lived experience.

Appendix: G Assumptions Regarding the Second Victim Phenomenon

- That I understand the current process of investigation for SIs
- That doctors involved in SIs are psychologically distressed
- That doctors will perceive barriers to seeking psychological help
- That doctors live with their distress at an SI
- That doctors will be honest with me about how they feel
- That doctors will see me as an NHS professional and so consent to take part in my research
- That doctors are second victims
- That I will know what I’m doing with DPA