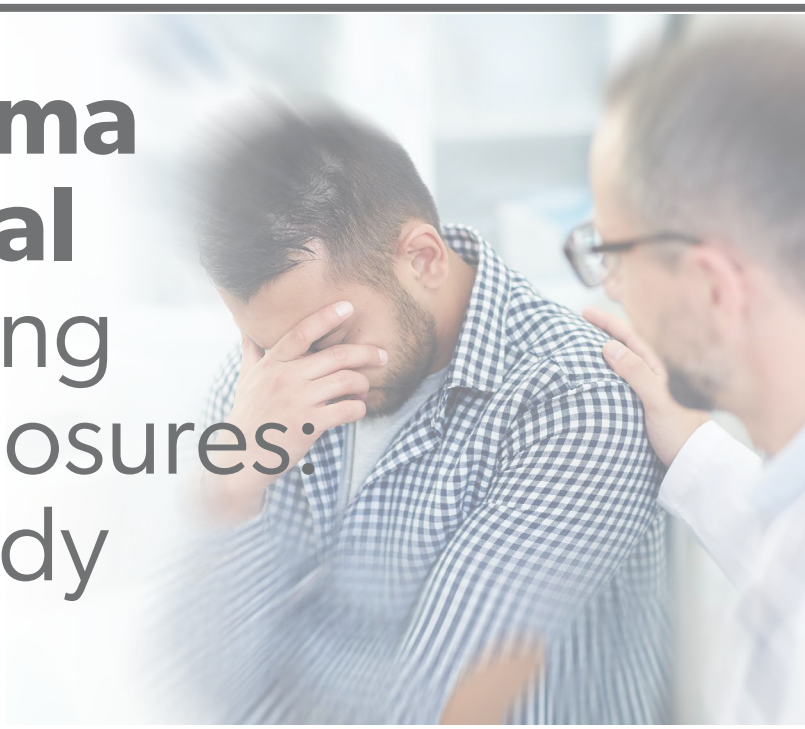
Vicarious trauma among hospital leaders following secondary disclosures: a qualitative study



Astha Patel, BHSc, **Simrat Soni,** MSc, and **Michael Miletin,** MD

Background: The findings of root-cause analyses of critical patient safety incidents are revealed to patients and families via "secondary disclosure" (SD). This process is often emotionally challenging. Although studies have demonstrated the psychological toll of patient safety incidents on frontline health care workers, the impact on physician and non-physician administrators who participate in SD meetings remains unexplored.

Objective: This study aimed to describe the experience of senior health care leaders who participate in SD meetings and explore the organizational support structures available to them.

Methods: We conducted a qualitative study at the William Osler Health System in Ontario. Eighteen senior hospital leaders (nine physicians and nine non-physician administrators) participated in semi-structured interviews using a validated interview tool. Thematic analysis was performed until data saturation was achieved.

Results: Five overarching themes emerged: (1) impacts on self-identity and leadership role, (2) spillover into personal life and coping mechanisms, (3) modulation of professional relationships, (4) emotionally challenging interactions with patients and families, and (5) recommendations for systemic improvements to mitigate burnout. Leaders commonly recalled

experiencing sadness (67%), extreme fatigue (44%), and self-doubt (44%) after participating in an SD. They perceived an absence of structured organizational support. Leaders requested additional training, structured debriefs, and peer support.

Conclusion: Hospital leaders who engage in SD meetings commonly experience significant psychological distress similar to that associated with second victim syndrome. Our findings highlight the urgent need for structured institutional interventions to support the well-being of leaders exposed to vicarious trauma in the aftermath of patient safety incidents.

KEY WORDS: disclosure, critical incident, second victim syndrome, hospital, management

Patel A, Soni S, Miletin M. Vicarious trauma among hospital leaders following secondary disclosures: a qualitative study. *Can J Physician Leadersh* 2026;12(1): 4-17. https://doi.org/10.37964/cr24801

Critical patient safety incidents are those causing significant harm to patients receiving health care services and are not related to expected clinical outcomes or known treatment risks. Like many other hospitals in Ontario, William Osler Health System, a multisite community teaching hospital, engages in a protocolized institutional response to critical incidents that begins with disclosure of the harm to the patient and family.[1] After the initial disclosure, root-cause analysis is undertaken and recommendations are developed to prevent a recurrence of the incident. This information is shared with the patient and family by the medical and administrative director of the department at a secondary disclosure (SD) meeting, which is mandated by *Ontario's Excellent Care for All Act*.[2]

Critical patient safety incidents have a significant emotional and psychological impact on patients and families.[3] The recognition that critical incidents also have negative effects on health care workers has led to the concept of the "second victim." A second victim may be "a healthcare 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."[4] Second victims may experience symptoms of burnout and some have described reactions akin to post-traumatic stress disorder.[5] Yet, in a study of 3171 physicians from Canada and the United States, only 10% felt that they were adequately supported by their organizations after being involved in an incident.[6] Similar findings have been reported for nurses, medical trainees, and midwives.[7]

"A second victim may be "a healthcare 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**."[4]

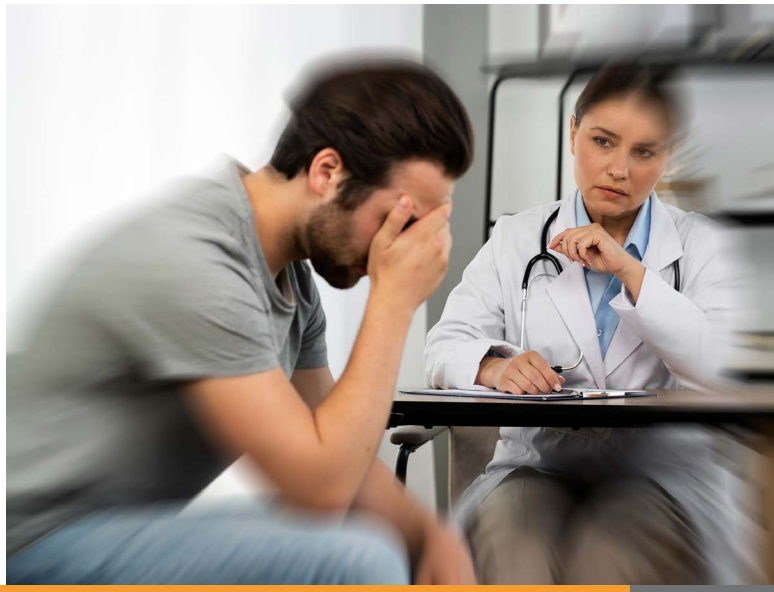
SD meetings may feature anger and hostility on the part of patients and families, as well as blame, accusations of malpractice, and threats of litigation.

Although senior hospital leaders are separated in time and space from the critical incident, they bear ultimate accountability for the quality and safety of the care provided by their clinical teams. To date, no research has examined the emotional and psychological impacts on physician and non-physician administrators who attend SD meetings. We conducted a qualitative study to determine whether senior hospital leaders vicariously experience second victim syndrome after participating in SDs of critical patient safety incidents and what organizational resources are available to support these leaders.

Methods

Departmental senior administrators and department physician chiefs serving between 2018 and 2023 were identified for recruitment through purposive sampling. This group was eligible for the study given their responsibility for providing SDs to patients and families. Each administrator and physician chief received an email invitation, which included a study description, the consent form, and the option to participate virtually or in-person. Respondents were interviewed by a trained member of the study team. During the interview, they were asked to reflect on an impactful SD meeting in which they participated as a senior leader. We used Scott and colleagues'[4] validated second victim Interview guide. To ensure confidentiality, each respondent was assigned a unique study ID, and anonymity was reinforced throughout the consent and interview process.

Audio recordings of the interviews were transcribed verbatim, and transcripts were thematically analyzed using NVivo (version 14; Lumivero, Denver, Colorado). Each transcript underwent multiple reviews to establish initial codes, which were subsequently organized into subthemes and overarching themes. An iterative approach was used and coding stopped once saturation was achieved. The respondents were analyzed as a whole, given their shared experience during SD. No subgroup analyses were planned or performed.



Ethics approval for this study was obtained from the William Osler Health System Research Ethics Board.

Results

We invited 30 senior administrative and physician leaders to participate; 20 agreed and 18 completed the interview for a response rate of 60%. Study respondents included nine physicians and nine senior administrative leaders. Their duration of leadership experience in the William Osler Health System ranged from 1 to 18 years (mean 5.3 years). Time since the impactful SD meeting ranged from 1 month to 5.5 years (mean 15.6 months). Five key themes emerged and are summarized below.

Theme 1: Participating in SD meetings has an impact on leaders' self-identity

Subtheme 1.1: Senior leaders feel an inherent responsibility to accept blame — Despite not being involved in the critical patient safety incident, 12 respondents acknowledged feeling a sense of indirect accountability for or ownership of the incident. Many felt a sense of helplessness, especially when incidents stemmed from issues outside their control.

S06: "But that got shoved on to me and it's always a weird position when you really haven't been involved, you get pulled in because you're the current manager and we need representation at the meeting. And so, you're part of this pretty emotional meeting and then you're given a follow-up item that is hard to implement, sometimes, some of those changes… But in these situations, it's so easy to think you are at fault because you are the manager. You're the head, right? And people pick up the phone, phone all the time and they call us and complain and say, '*well, it's your fault, it's your team*,' but it's not."

S05: "In some cases, later, they're ready just to jump on you because you're the representative of all that was wrong with what they think happened, right?"

Subtheme 1.2: Senior leaders experience emotional dilemmas when balancing conflicting responsibilities to their team — Nine respondents reported being tasked with multiple leadership responsibilities, including providing support, holding their teams accountable for errors, and being an exemplary role model. Balancing the need to provide support with the need to take remedial action was a struggle for seven of the nine respondents. Five respondents reported suppressing their own emotions and/or physical reactions to provide a positive example for their team.

S10: "I'd offer to talk at any point. Of course, this becomes more challenging when it's a recurrent performance issue, in which case you have to temper your supportiveness with holding people accountable to their issues and escalating further, but you try very hard to be supportive at the same time… doing what's necessary in order to put people in remediation, or even escalating beyond that to the Chief of Staff or to the College."

S12: "I think it does impact a bit, my relationship with colleagues who seem to have managed these with not enough vigilance and not enough sympathy."

Subtheme 1.3: The impacts of SD meetings have led to senior leaders reconsidering their career path — Four respondents considered leaving their position or changing departments or had declined promotions as a result of their experience with SD.

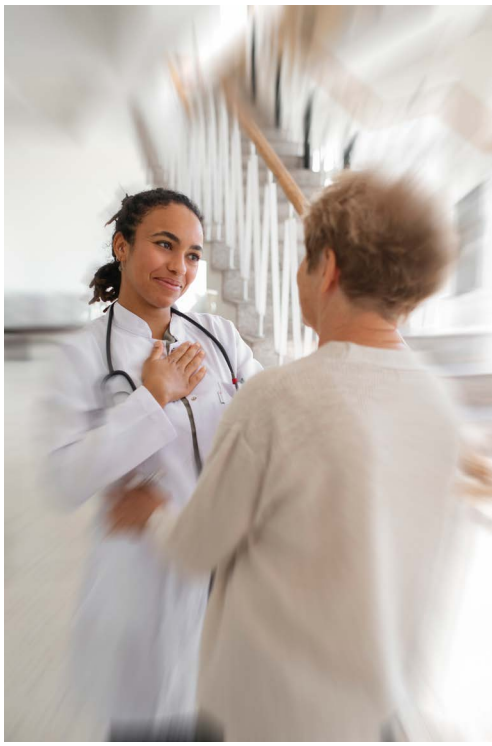
S05: "I needed to change something, but I was considering leaving the job. I was even considering leaving the job without another job to go to."

S12: "Occasionally I've thought, why am I doing this. I don't know if that comes under remorse, but, occasionally I think, why am I doing this? It's time to give it up."

Subtheme 1.4: Senior leaders experience a sense of loneliness in their leadership role — Two respondents reported that supervisors and colleagues did not understand the impact of participating in SD. Because they showed no visible indicators of trauma, respondents felt that their colleagues assumed that they were not affected. Accordingly, respondents struggled to identify resources for support and experienced loneliness in their leadership positions.

Balancing the need to provide support with the need to take remedial action was a struggle for seven of the nine respondents.Five respondents reported suppressing their own emotions and/or physical reactions to provide a positive example for their team.

S12: "Like the senior position I'm in… it's very difficult to seek help, like I think you are in the middle of the management. It's difficult for your seniors… so a senior lead because they don't know how much we are going through and at the same time, your colleagues or people who are under your leadership are already worried for you, so they are not supported from down below. So, you are a bit out. You find yourself a bit lonely in that space between senior leadership and junior followers. So, it's a tough position for people to be in."



S20: "I think that comes from the idea that even your supports… in that circumstance, I think even your supports don't get it because they've not had to do that."

Theme 2: The impacts of SD meetings on senior leaders are intertwined with their personal lives

Subtheme 2.1: Some senior leaders struggled to maintain separation between their work life and personal life — Ten out of 18 respondents said that SD meeting-related emotions and stressors impacted their personal lives. Because of their busy schedules, many senior leaders attended and/or prepared for SD meetings outside of working hours. Some respondents felt they neglected their personal needs and did not have space to self-reflect during or after SD meetings. Several reported that they related personally to the case (e.g., having a family member with a similar condition), which added to the emotional impact of SD meetings.

S07: "I guess I have not really had that addressed. Because I've moved on and done other things and had many other secondary disclosures and many other difficult situations, many other debriefings since. But I didn't address my need to unpack that from a psychological perspective for myself."

S04: "You know, I would think about it at home. I would think about the family. I would think about how did they… and even when that disclosure is happening, I wonder how they've managed for the past three months or six months or other time frame."

Subtheme 2.2: Some senior leaders rely on personal strategies to compartmentalize, thus limiting the impact of SD meetings on their well-being — Fourteen respondents used personal strategies to manage stress or process their emotions following an SD meeting. Examples included exercise, friendships outside the workplace, support from spouses, and professional support. Two respondents used

compartmentalization to avoid bringing emotions from SD meetings into their personal lives.

S10: "This idea about transference, or the patient's emotions; you don't have to take them on and, actually, there should be a degree of distance… you're going to see stuff that's horrible and terrible. And you do the secondary disclosures, and now you're talking to the family about the cases that you see, which is obviously even more difficult than just seeing them and participating. So, there is some sort of… you have to recognize, this is part of the job. And you have to be able to have some degree of distance to it, otherwise it's just not possible to do it for a long period of time."

S04: "I have a 30–45 minute car ride, I do the decompression on the way. I might talk to one of the other managers in the car on the way home, so that by the time I get home, I can do home stuff."

Theme 3: Participation in SDs modulates a senior leader's professional relationships with colleagues and the organization

Subtheme 3.1: Participating in SD meetings strengthened senior leaders' bonds with their colleagues — Fifteen respondents felt that participating in SD meetings improved relationships with their colleagues through the provision of emotional support and mentorship. Many respondents highlighted that this support was essential because of the of lack of system-level support.

S16: "And so there's this bond that forms because we've been through an emotional experience that we never want to have happen again, for us or for anybody else… for the family, more importantly."

S06: "In the workplace, I certainly have colleagues that I will call and they are people who I have either trained with, worked with closely for a long time, or have gone through challenges together."

Subtheme 3.2: Participating in SD meetings fostered a negative work environment for some senior leaders — Seven senior leaders reported a negative impact on professional relationships with their colleagues after attending SD meetings. Some respondents felt that their department was unjustly left to accept responsibility for critical incidents. Six respondents highlighted a feeling of poor communication with other senior leaders present at the SD meeting.

S05: "I also felt like I didn't have a safe place to talk about it, to be honest, like I just didn't have… I did have some spaces and places to talk about it, there were some staff colleagues to talk to, there were also times where it was not welcome, or that it was misunderstood, right?"

S10: "There have been situations where I felt that the department that I represent was unfairly left holding the hot potato. And really, I felt that the other departments didn't take their shared responsibility."

Subtheme 3.3: Participating in SD meetings shapes senior leaders' perceptions of the organization — Four respondents felt negatively about the organization's role in SD meetings, six felt that the organization played a neutral role, and five felt supported by the organization. Senior leaders felt that the organization took a compliance-centred approach to SD meetings. Most leaders who reported a "neutral" feeling indicated that the supports provided were inconsistent. All five respondents who felt supported by the organization attributed this perception to support received from work colleagues involved in SD meetings, rather than system-level supports.

S03: "I think its more, OK, we gotta get this done, its check, check, check, check mark, check mark. You know, government and compliance. But they don't really think about the men and women who are involved, for example… I don't think anybody really sat back and said, '*Oh my God, how are those doctors?*'"

S07: "Well my experience has been, it's been supportive, because we've come together as a group and supported each other to say, '*wow, how are you doing with this?*' I think, at least in my experience, the people that I have been in a secondary disclosure with have been very open to talking about it post-disclosure to have a check-in with each other. So, I find it very supportive."

Theme 4: Senior leaders face unique dynamics with patients and/or their families during SD meetings

Subtheme 4.1: Senior leaders facing violence, anger, legal threats and/or litigation from the patients and/or their families during SD meetings experienced profound emotional impacts and trauma — Three senior leaders reported experiencing an SD meeting that was physically and/or emotionally assaultive in nature. When recounting these experiences, respondents seemed deeply affected (e.g., tearing up, appearing demoralized, recounting vivid details).

S12: "So, there was some physical, you know, interaction by the husband towards me. He didn't hit me or anything, but, you know, approached me and stood up and shouted."

S07: "The extent to which this particular family expressed their anger was particularly difficult… it was assaultive, really, in nature."

Subtheme 4.2: Senior leaders strive to express their empathy and honesty while balancing the expectations and needs of the patient's families — Four respondents noted that emphasizing empathy and honesty was well received by patients and their families. Ultimately, most leaders who recalled empathetic SD meetings viewed SD meetings in a positive light and felt that the experience was meaningful and worthwhile for the family.

S19: "[You want] not only to take responsibility for what's happened, but you want to be transparent. So, you don't want to be hiding things. You want to let families know what has happened, and you want to try and be there for them and support them. I think no matter what the outcome is… and there's bad outcomes, like all the time… I think [the family is] always supportive in those cases.

S10: "I do remember that there was a heartfelt apology. Recognition of what we could have done better and making specific recommendations, and what we're doing differently and being transparent and forthright with the family. And in this case, I think it was well received."

Theme 5: Senior leaders suggest specific changes to the process and dynamics of SD meetings to promote well-being and combat systemic factors contributing to SD-related burnout

Subtheme 5.1: Senior leaders mostly support the use of simulation-based learning to prepare for SD meetings, if changes are made to the process — Six respondents reflected on the use of simulation-based training (i.e., scenarios played by actors to allow respondents to engage in a mock SD) to better prepare senior leaders for SD meetings. Although two respondents felt completely satisfied with simulation-based training, four expressed a sense of anxiety and unpreparedness. It was suggested that the organization consider providing more context on the purpose of simulation-based training and offer one-on-one or self-guided training for senior leaders.

Although two respondents felt **completely satisfied with simulation-based training**, four expressed a sense of anxiety and unpreparedness.

S16: "It [simulation-based training] was an active experience, like it wasn't an easy sort of experience and so, that was helpful. And then there was some feedback at the end. So, what we think went well, what we didn't think… you know, what you could have improved upon."

S11: "It just stresses me out, like, even having to play a role. I just don't know if I would benefit… for me, I don't know. I'd be more worried about the role-playing concept or just, like acting, and it seems so artificial."

Subtheme 5.2: Receiving external validation and team debriefs following SD meetings may help reduce the emotional impact on senior leaders — Eleven respondents valued recognition of their emotions following a difficult SD meeting. Six felt that, although debriefs are necessary to discuss the technical strengths and weaknesses of an SD meeting, they would appreciate a separate check-in that was strictly person-oriented (e.g., a call to ensure they are feeling supported and are connected to the resources they require to process their emotions). Three respondents recommended a peer-support program through which senior leaders would be connected to colleagues to confidentially and safely discuss their emotions and reactions to SD meetings.

S03: "There [should be a] check-in later, and I wouldn't call it a debrief, it's more of a check-in. Just to allow time to pass. But it's like an expectation, and that people understand that like it's not just an activity and it's not just tasks that we check off our list, it's something that we're integrating into ourselves into how we work and live here at the hospital, how we work with others and so… it would be further out but also more about the person. Like, '*are you doing okay? Do you need any support?*'"

S05: "I think there needs to be some acknowledgement of that as well, that this takes an emotional toll on people."

Subtheme 5.3: Structuring SD meetings with a protocolized process can reduce ambiguity, anxiety, and stress — Fourteen respondents said that formalizing the SD process would be beneficial. Seven also recommended including relevant subject-matter experts (e.g., ethics, legal, spiritual, and religious representatives) in SD meetings. Four suggested that an allocated self-reflection period should be included after the SD meeting to allow senior leaders to process their emotions before engaging in other work.

S04: "So, having a clear idea of what the process is meant to look like and what tangible product is meant to come out of it thereafter and having [something] standardized, even if it's a survey or a checklist."

S16: "I would say that there shouldn't be any meetings after that… And I would say that there should be like a mandatory hour, even half an hour would be helpful, so that there's no opportunity for another… Because then you gotta go from one meeting to the next and… They're exhausting, you do feel exhausted after a meeting like that. It's tense."

Subtheme 5.4: Key changes to the training process for SD meetings can help senior leaders feel better prepared — Training was identified as a key area of improvement. Four respondents felt that they would benefit from self-assessing their training needs and engaging in training that they would find helpful. Five respondents expressed an interest in observation-based training (e.g., viewing recordings of SD meetings, listening to an audio recording).

S07: "So, don't assume that because someone is an experienced leader, that they're good at this. Because this is a very different type of leadership. So, I would approach it from a novice-to-expert perspective in that you build competencies."

S06: "If there was a way to… record, with permission, and be able to listen to the conversations in a training room where everyone could watch or listen to it… I think that's the type of training that would go a long way."

At the end of the interview, respondents were asked whether they experienced certain symptoms of vicarious trauma. Respondents responded yes or no. Those responding yes were asked to elaborate on their experience.

Training was identified as a key area of improvement. Four respondents felt that they would benefit from self-assessing their training needs and engaging in training that they would find helpful. Five respondents expressed an interest in observation-based training

Discussion

This study explored the experience of senior physician and non-physician hospital administrators at William Osler Health System who participate in SD meetings. Our findings demonstrate that such participation has a significant psychological and emotional impact on hospital leaders.

We found vicarious trauma in physician and non-physician leaders who are not clinically involved in patient safety incidents but bear accountability for the provision of safe care in their work units. Initially described in health care workers providing care to the affected patient, the second victim syndrome was evident in our population. Scott et al.[4] described

"haunted re-enactments, often with feelings of internal inadequacy" as a common experience among health care providers directly involved in safety incidents. We saw a similar impact on personal identity in our study, with 44.4% of respondents feeling a sense of self-doubt and inadequacy. Unique to our population is the feeling of loneliness and an inherent responsibility to accept blame, which have not been linked to the impact of vicarious trauma in other populations.

The presence of compassion fatigue may help explain our findings. Compassion fatigue is related to "the stress resulting from helping or wanting to help a traumatized or suffering person."[8] In our analysis of subthemes 2.1, 2.2, and 4.2, we found that leaders often suffered a degree of compassion fatigue when they related closely to the safety incident discussed at an SD. A reflective self-care stance is a key strategy for decreasing the risk of compassion fatigue and facilitating the development of compassion satisfaction.[9] Our analysis suggests that senior administrators seek similar opportunities to reduce the emotional burden of vicarious trauma, as seen in subtheme 5.3. Although the current literature has highlighted compassion fatigue in health care providers who are directly involved in patient care (e.g., palliative care physicians, psychologists, urgent care nurses), our study suggests that it may be a key driver of the vicarious second victim syndrome faced by senior leaders participating in SD meetings.[8-10]

There is a paucity of data on interventions to mitigate risk factors that contribute to vicarious second victim syndrome.[11] Our study provides suggestions for strategies to combat this syndrome in affected senior leaders. First, debriefs are important in facilitating positive emotional experiences and well-being among health care professionals following a traumatic event.[12] Senior administrators derived a similar benefit from group debriefs following SD meetings, as seen in subtheme 5.2. Unique areas for improvement include the implementation of a "person-centred debrief," where emotional experiences are the focus of the conversation. Providing structure to the SD meeting process (preparatory work, meeting, and post-meeting debriefs) was also identified as a key area of improvement. Further research is needed to explore the feasibility and benefit of implementing these interventions.

Strengths and limitations

To our knowledge, this study is the first to explore the concept of a vicarious second victim syndrome among physician and non-physician hospital

administrators who participate in SDs of critical patient safety incidents. Our study population consisted of a variety of leaders with diversity in their degree of experience participating in SDs. Although our participant response rate was reasonable at 60%, our study size remains small, and our results are exploratory and hypothesis-generating in nature. Although the respondent group consisted of an equal number of physicians and administrators, we did not intend, a priori, to compare the two categories of respondents. As a result, our ability to compare these groups to one another is limited by a lack of data saturation within each subgroup.

This was a semi-structured, interview-based study and, as some respondents reflected on experiences that had occurred several years in the past, their recollections may have been affected by recall bias. As a single-centre study, our findings may not be transferable to other centres with differing processes for SD.

Conclusion

Hospital leaders participating in mandated SD of critical patient safety incidents experience a vicarious form of second victim syndrome. This finding warrants replication in other health care administrative contexts as well as an exploration of system-level initiatives to mitigate this threat to personal and professional well-being.

References

1. Patient safety incident management toolkit. Brampton: William Osler Health System; 2019.
2. Excellent care for all act, 2010, S.O. 2010, c. 14. Available: https://www.ontario.ca/laws/statute/10e14
3. Prentice JC, Bell SK, Thomas EJ, Schneider EC, Weingart SN, Weissman JS, et al. Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. BMJ Qual Saf 2020;29(11):883-94. https://doi.org/10.1136/bmjqs-2019-010367
4. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009;18(5):325-30. https://doi.org/10.1136/qshc.2009.032870

5. Rassin M, Kanti T, Silner D. Chronology of medication errors by nurses: accumulation of stresses and PTSD symptoms. Issues Ment Health Nurs 2005;26(8):873-86. https://doi.org/10.1080/01612840500184566
6. Waterman AD, Garbutt J, Hazel E, Dunagan WC, Levinson W, Fraser VJ, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. Jt Comm J Qual Patient Saf 2007;33(8):467-76. https://doi.org/10.1016/s1553-7250(07)33050-x
7. Seys D, Scott S, Wu A, Van Gerven E, Vleugels A, Euwema M, et al. Supporting involved health care professionals (second victims) following an adverse health event: a literature review. Int J Nurs Stud 2013;50(5):678-87. https://doi.org/10.1016/j.ijnurstu.2012.07.006
8. Borges EMN, Fonseca CINS, Baptista PCP, Queirós CML, Baldonedo-Mosteiro M, Mosteiro-Diaz MP. Compassion fatigue among nurses working on an adult emergency and urgent care unit [in Portuguese, English abstract]. Rev Lat Am Enfermagem 2019;27:e3175. https://doi.org/10.1590/1518-8345.2973.3175
9. Sinnathamby A, Ibrahim H, Ong YT, Ravindran N, Wan DWJ, Tan JH, et al. Towards a theory of compassion fatigue in palliative care and oncology: a systematic scoping review. Am J Hosp Palliat Med 2025;42(1):10499091251315183. https://doi.org/10.1177/10499091251315183
10. Jeanmonod D, Irick J, Munday AR, Awosika AO, Jeanmonod R. Compassion fatigue in emergency medicine: current perspectives. Open Access Emerg Med 2024;16:167-81. https://doi.org/10.2147/OAEM.S418935
11. Rauvola RS, Vega DM, Lavigne KN. Compassion fatigue, secondary traumatic stress, and vicarious traumatization: a qualitative review and research agenda. Occup Health Sci 2019;3(3):297-336. https://doi.org/10.1007/s41542-019-00045-1
12. Evans TR, Burns C, Essex R, Finnerty G, Hatton E, Clements AJ, et al. A systematic scoping review on the evidence behind debriefing practices for the wellbeing/emotional outcomes of healthcare workers. Front Psychiatry 2023;14:1078797. https://doi.org/10.3389/fpsyt.2023.1078797

Authors

Astha Patel, BHSc, is a medical student at the University of British Columbia School of Medicine. When this study was conducted, she was a student in the summer student research program at the William Osler Health System in Brampton, Ontario.

Simrat Soni, MSc, was a senior advisor, Medical Affairs, with the William Osler Health System.

Michael Miletin, MD, MSc, is the medical director of quality and patient safety at William Osler Health System in Toronto, Ontario.

Sponsorship and funding
The authors have no conflicts of interest to disclose.

Author attestation
All three authors contributed to the research proposal, the ethics application, and formulation of the interview guide. SS led respondent recruitment. AP conducted and transcribed all interviews. AP conducted thematic analysis with SS and MM to resolve queries. MM and AP wrote the manuscript. All authors approved the final article.

Correspondence to:
apatel9@student.ubc.ca