

Interviewing colleagues - Ethical and methodological challenges

Margrethe Aase, University of Bergen, Norway, e-mail: Margrethe.Aase@isf.uib.no

Introduction

"How can we not feel anxious about making private words public, revealing confidential statements made in the context of a relationship based on a trust that can only be established between two individuals?" [1, p. 1]

I just wanted to talk to them. Listen to them. Who were they behind their professional masks? How did they bear their professional challenges, not least the existential challenges of everyday medicine? Could anyone show me the way to an enduring life as a physician? I had been watching them at a distance for years, and suddenly I was in their midst, as a junior doctor at the Department of heart disease, having lunch with them, working side by side. A young colleague with so many questions and doubts. But why not just share a bottle of wine and talk it over? Why a scientific approach, and was it even possible, being so close to them as an interviewer in a research project? The answers are yet to be found, and this essay is a step on that journey. In reference to Steinar Kvale and Svend Brinkmann [2] [3], I will try to explore some of the ethical dilemmas that may arise choosing my own colleagues as informants. I will also comment on some methodological aspects. As the heading suggests, I will delimit this essay to focus on the part of my PhD-project where I am interviewing doctors facing issues related to life and death. The other three parts of the project comprise interviewing the patients, studying high-risk information conversations and philosophically outlining the concept of "vulnerability" in a medical context. It should also be mentioned that I have so far interviewed five physicians: four male cardiologists and one female general practitioner.

Beneficial?

In his book "Interviews: an introduction to qualitative research interviewing", Steinar Kvale points out at least five important ethical issues at the start of an interview study: beneficial aspects, informed consent, confidentiality, consequences and the researcher's role [2, p. 119-120]. The first question is maybe one of the most essential ones to be asked at any type of research whatsoever: What are the beneficial consequences of this study? How can the study contribute to enhancing the human condition?

In this research project we wanted to explore existential experiences and perspectives among doctors and patients with serious heart disease, in order to provide better understanding and care for the sick person as well as for the health care professional. Our aim was to develop scientific knowledge to be used in clinical practice when dealing with inevitable conditions of human life and death. Above all, our motivation was supplementing or correcting the often criticized "biomedical" focus on the suffering individual. Due to the fact that most studies in this field so far have been performed by and among nurses, we were eager to examine how physicians reflect upon these themes. Recent publications have outlined to some extent how

they cope with patients` death [4] but a broader existential view is merely to be found in more "alternative" or spiritual medical journals, or in personal reflections` columns.

How, then, could this project be beneficial? And to whom? Our main concern is - and of course should be - to optimize the treatment and care for our patients. If there is a link between communication and care, studying the way doctors and patients reflect upon and talks about central phenomena of life hopefully will yield knowledge that could be used to improve this care. But what about the physicians, their needs and interests? Would it be beneficial to them? Social anthropological studies of medical students suggest that through adaptation to the profession culture and development of a professional identity, their language is narrowed and their capability of perceiving what is outside a biomedical view is reduced [5] [6]. There might be several reasons for such a development, the most commonly mentioned being the need of a professional distance and focus, providing the ability to handle life-threatening medical conditions and protecting oneself from exhausting emotional involvement. However, in situations less critical, this capability might function as a barrier that makes physicians insensitive to essential information concerning a patient and his or her needs. Allyson L. Robichaud, professor in philosophy at Cleveland State University, also suggests that doctors may protect themselves in an inexpedient way when emotional engagement is looked upon as a threat to good health services or a burn-out-cause, because emotions are important sources of knowledge to be used when analyzing decisions, actions, outbursts or statements in everyday clinical medicine [7].

An ethical dilemma hereby occurs, if our interview design "forces" the physicians to focus on and talk about things they are trained to rule out in order to carry out their professional task in an enduring and beneficial manner. For example, I ask them about difficult encounters with death. Through medical school, we learn to suppress our emotional reactions in this field, from dissection classes and onwards.[8] "Mike" needed some time before he was able to recall such an experience, and when he did and started talking about it, he almost relived the horror of that situation. How beneficial was that for him? This was by far the heaviest emotional burden for me as a researcher and colleague. Being too superficial and considerate might reduce the quality of the research in terms of credibility and validity, but would most likely reduce the discomfort of my colleagues. Being too invasive and direct might stir up painful experiences and feelings repressed to survive a tough job, but could bring forth valuable research material. This also turned out to be a methodological dilemma, which I will address later on. How to find the balance? Transcription of the first interviews made me see how I avoided following up the "difficult" stories of the interviewees. After the tape recorder was switched off, I tried to ask them how they experienced the questions. Nobody reported uncomfortable or too intimate questions. On the contrary, "Mike" suggested that I could profitably have followed him deeper into the very painful experience he chose to share in his interview, even though it was tough.

Yet there is a long distance from not being harmful to being beneficial. Our main purpose of the study was to gain knowledge to provide better care for the patients and the physicians on an existential level. If we - through description and analysis of their personal life-world as humans and professionals - could identify valuable steps towards that goal, the study could be seen as beneficial for both groups. Even so, the concept of "care" itself is an ethical dilemma,

demanding its own essay to be scrutinized. Another important consideration is the “ethicism” that – according to Brinkmann and Kvale – “often permeates the discourse of qualitative research, that is, the implicit idea that qualitative research is ethically good in itself, or at least ethically superior to the uncaring quantitative approaches.”[3, p. 157] They question this idea by pointing at several shortcomings of an unreflective qualitative ethicism: the asymmetrical power relation, the interview as an instrumental, one-way dialogue that even might be manipulative, and the interviewer’s monopoly of interpretation. Suggesting an antidote, they highlight the Aristotelian virtue “phronesis” or practical wisdom, involving the skill of “thick ethical description, the ability to see events in their value-laden contexts, and judge accordingly”. [3, p. 160]

Informed consent

Physicians in general ought to know the meaning of informed consent better than most people, its importance in modern medicine being taught in most medical schools, at least in the western world. However, the preliminary steps towards obtaining informed consent from my colleagues were not as straightforward as desired. I first presented the study for them November 2005 in a so-called lunch lecture, an educational forum taking place twice a week at our Cardiology Department, in which about one third of them were present. In April 2006 I e-mailed a new orientation and invited every physician in our Department to participate. Waiting for the necessary approval from the Ethical Committee, I sent two of them a special e-mail, asking for a pilot interview. One of them politely declined, stating that he did not feel like participating in this kind of study. The other answered in one word: "Fear." I replied by saying I interpreted that as a "no". He then asked me to give him a bit more information face to face, resulting in enrolment. Three other men responded spontaneously to the common e-mail and wanted to participate. My main supervisor also asked a female GP to enrol as a contrast or variation to the cardiologists and thoracic surgeons.

How much information about the study to be given in advance, was another topic to be taken into account. I decided to give them the freedom to read the entire project account if they wanted to, e-mailed as an attachment in addition to one paper addressed specifically to the physicians, as outlined by the Ethical Committee. This was an attempt to make sure they had as much information as possible when deciding whether to enrol or not. It was important to me to be open about every aspect of the study so that they could feel secure, but it was also due to the fact that many of them were unfamiliar with and even sceptical towards qualitative research. It turned out that most of the interviewees only read the information paper, and received oral information before the interview took place. Being an exploratory study, none of us could know exactly how the interviews would proceed, and the extent of informed consent could thereby be discussed. However, giving them the possibility of obtaining details in terms of setting, form and agenda, they at least had the chance of making a fairly good judgement. Of course, this could be seen as priming, and most likely influenced how they prepared themselves before the interview. They were not allowed to see the interview guide in advance, though, and my impression of their accounts was interactive spontaneous reflections throughout the different topics.

My major concern at this stage was how to make people enrol without pressuring anyone into something they did not want. The enrolment process was strongly influenced by the fact that I

am their young inferior colleague who did not want to cause any trouble, but still needed participants in order to have my PhD done in a proper way. I will comment the superior-inferior- and familiarity aspect further methodologically later in this essay. Ethically, it was a challenge to find the balance between being too pushing and being too afraid of causing any inconvenience. Should I continue to give personal invitations and reminders, or should I just wait patiently and go to another hospital if I did not get as many interviews as needed? We discussed this several times both at the hospital and at the Section for general practice, and we decided to continue the recruiting as initiated, through e-mail and personal contact, judging the ethical balance along.

Confidentiality

While my concerns and worries were as outlined above, my colleagues were more preoccupied with anonymity and how we were to guarantee it in a small and transparent environment. Even though several precautions were made and explicitly communicated, we got to know that this was one of the main causes why the physicians hesitated to enrol. The informants were free to choose where they wanted the interview to take place - at the hospital, at the Section for general practice or elsewhere - providing a relaxed and undisturbed setting. They were promised that no information potentially recognizable to others should be published, and that they were free to withdraw themselves or parts of the material from the study at any point during the project. Their names were changed already at the start of the interview, and the written informed consents, transcripts and tape recorder were kept locked up when not in use. No one except me and my main- and co-supervisor had access to the interviews and the informants` identity. The files were saved at my university computer with a special entrance code, and also at a memory stick to have back-up copies.

However, these formal, practical precautions could not hide the fact that enrolment implied opening up to someone they might have to work with for the rest of their lives. If they revealed sensitive information about themselves or others, it might forever change a colleague`s impression, not "just" an unfamiliar researcher whom they never had to see again. And how would this information be received and understood by the interviewer? In "The Weight of the World", Bourdieu has outlined some highly relevant ethical and methodological perspectives performing interview studies. He talks about the "intrusion" inherent in social exchange [1, p. 608], and how he let his investigators choose their respondents from people they knew or to whom they could be introduced by people they knew: "For social proximity and familiarity provide two of the conditions of "non-violent" communication".[1, p. 610] "Even the most brutally objectifying questions have no reason to appear threatening or aggressive because the interviewee is perfectly aware of sharing the core of what the questions induce the other to divulge, and of sharing, by the same token, the risk of that exposure. And similarly, no interviewer can ever forget that objectifying the respondent means objectifying oneself(...)"[1, p. 611] This illustrates how knowing the informants under some circumstances may be an advantage, protecting them against reductionism and enhancing the communication by providing an agreement on how nonverbal and verbal signs and utterances are to be interpreted.

Consequences

Looking at the probable consequences of this study for the individuals and the group as a whole, the question of intervention came up. Methodologically, performing these interviews could be seen as an effort setting a new - or perhaps old? - agenda in modern medical discourse. According to Michel Foucault, an assertion, from the 19th century onwards, was no longer medical – it fell “outside medicine”, into the realm of individual fantasy or popular imagination – if it encompassed concepts being at the same time metaphorical, qualitative and substantial. [9, p20] To belong to a strict discipline, a statement must fulfil complex and heavy demands. Before it can be judged as true or false, it must be “in the true”. [9, p21] Being socialized into any such a discipline will exert an influence on the linguistic codes not always evident to the members, as outlined by Steen Wackerhausen. [10, p67-71] Exploring this further in a medical context implied in our case letting the physicians describe as much as possible in their own terms after introducing existential subjects. Charles Taylor underlines the importance of articulating what is implicit and obscure, enabling us to focus on certain characteristics of reality and interpret them in new ways. [11] It also establishes a public room, creating prerequisites for interpersonal conditions. Being a medium for specifically human conditions, language does not solely provide articulations as descriptions, but as means of changing and creating new conditions. [11, p. 11, preface by Petter Nafstad]

How did my colleagues experience this intervention? "Celine" stated that being asked these kinds of questions started a process of reflection. "Eric" asked for a follow-up conversation after some weeks, because he wanted to make sure his perspectives and experiences were captured in the "right" manner, and he also had further stories he would like to add. "Mike" underlined that this study entailed something positive for the entire Department. "Richard" was eager to know the analysis results and what kind of knowledge it would produce, and he also wanted a follow-up conversation. Yet it is too early to see the full extent of this project's consequences, and probably follow-up studies will be needed. As Bourdieu puts it: "(...) researchers have some chance of being truly equal to their task only if they possess an extensive knowledge of the subject, sometimes acquired over a whole lifetime of research, and also, more directly, through earlier interviews with the same respondent or with informants." [1, p. 613]

Researcher`s role

The last of Kvale's five main ethical issues concerns the researcher's role. [2, p. 117] He underlines the fact that the interviewer is the main instrument for obtaining knowledge, making his or her person and integrity of critical importance. Interviewing my own colleagues turned out to be difficult for me in the manner of defining a specific "role" as a researcher. Who was I to them but Margrethe, with whom they worked? Was the threat of "faking friendship" present [3, p165] [12, outlined by Duncombe and Jessop], or would the social proximity provide the benefits described by Bourdieu? My assumption is that being inferior to them made the power relation in the interviews more symmetrical than otherwise. It also made them to a lesser extent one-way dialogues, in the sense that for instance "Mike" turned the situation upside down by asking for my religious opinions in the middle of the interview, as if we had an ordinary conversation. In the same way "Richard" started comforting me at the end of his interview, when I confided something personal to him as his younger colleague due to the topic we were discussing. Little by little I understood why I was so nervous and exhausted performing the interviews: "The social proximity to the person being questioned

undoubtedly explains the malaise that practically all the researchers placed in such a position admitted experiencing, sometimes throughout the interview, sometimes beginning with a particular moment in the analysis: in every case, the questioning quite naturally tends to become a double socioanalysis, one that catches and puts the analyst to the test as much as the person being questioned". [1, p611] Even so, I felt enormously privileged and grateful having these conversations I had longed for should be a part of my education.

The Danish researcher and therapist Jette Fog has thoroughly discussed the role and moral responsibility of the interviewer. She describes how the openness of the conversation can serve as a "Trojan horse", bringing the researcher behind the inner borders of the other. [13, p. 20-22] How to proceed in a landscape containing openness as well as "the untouchable zone" [14, p. 163 and 165], is one among several moral aspects an interviewer is exposed to during this kind of study [13, p196-299] She concludes: "Earlier I asked: with which right am I to enter another human being's inner life? And the answer is: I have no such right. Only the right which the other person gives me. Or the right, which my hopefully correct perception of and respect for his borders give me." [13, p. 299, author's translation]

Conclusion

So what will they tell me, and what will they keep to themselves that they might have told an unfamiliar interviewer? What will I dare to ask them, and where do I find the borders of how far to go in my questioning? How will my access as a colleague colour the research material, the analysis and presentation? Where are my blind spots? Is it simply too naive to call this research at all? Yet I have more questions than answers, but this is perhaps the privilege of the novice researcher. In this essay I have tried to explore some of the challenges these questions represent, and I hope to explore them further throughout my project.

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References

1. Bourdieu, P., *The Weight of the World : social suffering in contemporary society*. 1999, Cambridge: Polity Press.
2. Kvale, S., *Interviews: an introduction to qualitative research interviewing*. 1996: p. XVII, 326 s.
3. Brinkmann, S. and S. Kvale, Confronting the ethics of qualitative research. *Journal of Constructivist Psychology*, 2005. **18**(2): p. 157-181.
4. Redinbaugh, E.M., et al., Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors. *Bmj*, 2003. **327**(7408): p. 185.
5. Becker, H.S., *Boys in white : student culture in medical school*. 1977, New Brunswick, N.J.: Transaction Books.
6. Sinclair, S., *Making doctors : an institutional apprenticeship*. 1997, Oxford: Berg.
7. Robichaud, A.L., Healing and feeling: The clinical ontology of emotion. *Bioethics*, 2003. **17**(1): p. 59-68.

8. Johansson, K.A., et al., [Destiny-zapping--medical education, students' world view and the ethical challenge]. *Tidsskr Nor Lægeforen*, 2001. **121**(13): p. 1618-21.
9. Foucault, M. and E. Schaanning, *Diskursens orden : tiltredelsesforelesning holdt ved College de France 2. desember 1970*. 1999, Oslo: Spartacus.
10. Wackerhausen, S., *Humanisme, professionsidentitet og uddannelse: i sundhedsområdet*. 2002, København: Hans Reitzels Forlag.
11. Taylor, C., *Autentisitetens etikk*. 1998, [Oslo]: Cappelen akademisk forl.
12. Mauthner, M.L., *Ethics in qualitative research*. 2002, London: Sage.
13. Fog, J., *Med samtalen som udgangspunkt : det kvalitative forskningsinterview*. 1994, København: Akademisk Forlag.
14. Løgstrup, K.E. and V. Mortensen, *System og symbol: essays*. 1982, [København]: Gyldendal.