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ORIGINAL ARTICLE

Interviewing one's peers: methodological issues in a study of health professionals

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Abstract
Objective. Although health professionals are increasingly undertaking qualitative interviews with professional peers, there is little literature regarding the methodological implications of this process. The aim of the study was to elicit from informants their views on being interviewed by a fellow health professional. *Design.* Semi-structured interviews with nine general practitioners (GPs), three rheumatologists, and three physical therapists, with a substantive focus on perceptions of osteoarthritis. The interviewer was a GP, and informants were asked for their reactions to being interviewed by a fellow professional. Data were analysed by hand, using a thematic approach. *Setting.* Primary care clinics and practices in the UK. *Results.* Although reassured to the contrary, many informants viewed the interview as a test of their professional knowledge. The interview was also seen by some GPs as serving an educational process, with the interviewer as an authoritative source of clinical information. There were some indications of professional vulnerability among informants in relation to possible scrutiny of their practice or knowledge, though none reported a negative experience of the interview. Notions of professional identity appeared central to many of the issues that emerged. *Conclusion.* The nature of the relationship in interviews involving professional peers creates specific methodological issues, which have important implications for qualitative research in primary healthcare. There are both advantages and disadvantages to interviewing professional peers, which should be considered in the light of the objectives of a particular study.

Key Words: *Family practice, interviews, methodology, professional peers, qualitative research*

In interview research, the relationship between interviewer and informant is central [1–5]. Very often, this issue is framed in terms of a status or knowledge gap. Hence, the "professional" expertise of the practitioner may be contrasted with the "lay" knowledge of the patient, with corresponding disparity in terms of power [6,7]; this has important methodological and ethical implications [8,9]. The interviewer is often of higher social status, with no prior or future relationship with the informant [10]. However, there are also situations in which researcher and informant occupy a similar role or status, possess a similar body of knowledge, and share an ongoing professional relationship. Whilst the methodological implications of such situations have been examined in the context of social [10,11], educational [12], and healthcare research [13,14], literature in this area is sparse. However, as clinicians are increasingly using qualitative methods to study and evaluate aspects of primary healthcare [15–22], an understanding of these issues has important implications.

> The methodological implications of interviewing professional peers are under-explored in the literature, yet are potentially important in primary care research.
>
> - General practitioners may feel the interview is a test of knowledge or competence, despite assurances to the contrary.
> - The peer relationship and notions of professional identity appear to underlie the nature and dynamics of the interview process.
> - The pros and cons of interviewing professional colleagues should be evaluated in relation to a study's specific objectives.

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In this article we report insights gained from a study of health professionals' conceptions of osteoarthritis. Although attitudes and beliefs concerning osteoarthritis were the principal substantive focus of the study, a secondary aim was to explore informants' experience of being interviewed by a professional peer.

Material and methods

We conducted interviews with 15 practitioners: 9 general practitioners (GPs), 3 consultant rheumatologists, and 3 community physical therapists (PTs). These clinicians had a median of 24 years' post qualification experience (range 7–37 years), and eight were male. They were chosen to represent a range of clinical experience and practice settings (e.g. for GPs, both single-handed and group practices, and for rheumatologists, both university and non-university hospitals). Participants were approached by letter regarding participation. All of the rheumatologists and PTs approached agreed to participate; we needed to approach 12 GPs to secure the 9 interviewees. The basis of sampling was principally to obtain the views of GPs, but we included smaller numbers of the other two professions to provide some comparative data. The Local Research Ethics Committee approved the study and all participants gave informed consent. One of the authors (LC), who is a GP, carried out the interviews in north-west England over a three-month period.

In a semi-structured format, we asked informants about their understanding of osteoarthritis as a clinical entity, and how this influenced their approach to clinical work – e.g. whether they regarded osteoarthritis as an issue of disease or of normal change, and how they explained osteoarthritis to patients. At the interview's conclusion, we sought informants' views on what it was like to be interviewed by a professional peer. Specifically, we asked: "What was it like being interviewed by a fellow professional?" Further questions or probes were then used as appropriate.

The interviews lasted between 20 and 60 minutes, and the topic of being interviewed by a peer commonly occupied the last 5–10 minutes. We audiotaped the interviews and analysed the transcripts by hand, using thematic analysis [23]. Although data analysis was primarily inductive, it was also guided by an a priori understanding of issues likely to be raised. Sections of text were gathered under broad categories, which were given provisional descriptions. As analysis proceeded, categories were refined, merged, or split, and their descriptions modified, as appropriate [24]. As well as subsuming data under emerging themes, we also sought data that did not fit these themes ("deviant" cases) [25]. Both researchers coded a subsample of three interviews to check consistency.

Results

The interview as an examination

The theme emerging most prominently related to the interview being perceived as a test of factual knowledge. Three GPs volunteered this perception of the interview, with an anticipation of being given a pass or fail, despite the fact that the interview was focusing on a conceptual, not a factual, understanding of osteoarthritis. Although informed at the outset that there were no right or wrong answers, one GP replied "but you'll fail me if I get the wrong answers" (GP8). Another commented:

> *It was almost like a viva wasn't it really, I was checking that I'd . . . it makes me think how do I, am I up to date? Am I, have I missed stuff out and* [–] *I've forgotten a whole branch of therapies that's available.* (*GP3*)

In the introductory letter it clearly stated that no preparation was necessary prior to the interview, yet one GP was concerned as to whether some prior reading should have been done:

> *I haven't felt that I've been checked over, but I was thinking as to what I should do, should I read over something and then I didn't, I thought "no, let me be spontaneous and think of the answers when you ask me as to what it is", so I just left everything you know and, er, just I've answered to you whatever I've thought at this moment, but it did come to my mind that, you know, supposing I can't come up with the answers then* [*laughter*]. (*GP4*)

One PT (PT2) remarked "am I doing all right?" in the middle of the interview, and another (PT3) asked "I hope I've answered it all right?" at the end, in such a way as to suggest a perception of their knowledge being under scrutiny. Only one of the informants, an experienced consultant, explicitly demurred from this perception, and displayed no reservations regarding answering the questions:

> *I mean perhaps because I work in the environment of sort of doing this sort of thing I'm, er, you know it doesn't bother me unduly.* (*Cons2*)

One GP was concerned that the interview was a way of monitoring GPs for other reasons, and this was understood to be a reference to issues concerning

medical competence and fitness to practise medicine:

> *Well we're all a bit paranoid, we think everyone's watching us GPs, and you know, where's this information going?* [*laughs*]. (*GP9*)

All informants were, however, positive about the overall experience of the interview.

The interview as an educational process

A second, allied theme concerned a perception of the interview as an educational process. Five GPs asked for feedback on their performance, and were anxious to know if there were any glaring gaps in their clinical knowledge, or if their clinical practice differed significantly from others'. They appeared to see the interview as having an educational content, with opportunities to ask questions, and to treat the interviewer as an expert resource. It made GPs question whether their knowledge was up to date, and whether they had learning needs:

> *I'd like to know where I stand in terms of my knowledge and if there was something locally that was organized for GPs to explain what the current thinking is and the current recommended ways of treatment, I think that would be useful.* (*GP5*)

Another commented similarly:

> *I like to think that I'm a student still, I like to learn something. I don't know whether you feel that I need to learn anything more, I'm sure I do, I'm sure you've already detected the the, er, profound ignorance that I exhibit about this particular subject and perhaps you can enlighten me on it?* (*GP6*)

One GP's comments on the interview suggested a process of justification:

> *Okay I am a GP, I'm an average GP there are 50 better than me but there are 50 worse than me. [laughs] I'm right in the middle . . . but I'm prepared to learn all the time, definitely, I'm not shy of asking questions, I'm not shy of learning.* (*GP1*)

This informant appeared to be conscious of the "correct" attitude to display regarding professional updating in the presence of a professional colleague, and seemed to engage in a form of self-legitimization.

The consultants and the PTs did not appear to see the interview in an educational light. Presumably this was because consultants' knowledge is considered authoritative, such that they do not require information from a GP, and PTs do not consider somebody from another profession eligible to comment on their expertise. One PT's comments suggested that the interview was more an opportunity to inform the interviewer than vice versa:

> *When you're interviewed by another physiotherapist you are always a wee bit worried that they're going "he's talking rubbish" and "that's wrong", and so that's so quite interesting because you've a chance to air your views as a professional, but as a different professional.* (*PT1*)

Relationship with the informant

The idea of the interviewer being the informant's peer was not wholly consistent between or within interviews. In one interview, the interviewer was treated differently at different stages. In some instances she felt as if she were a student being related a cautionary tale. At other times, she was treated as another doctor with expertise, when asked for answers to factual clinical questions. Another GP appeared to have forgotten that the interviewer was medically qualified, and gave answers that assumed little medical knowledge. Some informants aligned themselves with the interviewer, and expressed the camaraderie of both being medical professionals.

> *INT: As I introduced myself I mentioned I'm a part-time GP, I was just wondering what it was like being interviewed by a fellow professional?*
> *GP3: Oh right, erm* [–] *easier than a non-professional, yeah, you know well I think you understand what I'm saying more than somebody say . . . easier to talk to.*

Another informant expressed a form of solidarity in the face of potential criticism of the profession:

> *INT: I wondered if there were any ways that you can help manage them while they're on the waiting list or do you do anything different?*
> *GP9: No, I mean if somebody has really deteriorated then I'll, you know, try and do something but I don't think that's for the doctors to, it's for the politicians to sort out really, you know, we get the moans 'cause we're the front line* [*laughs*].

Discussion

When interviewing expert professionals, the researcher's identity is influential. Academic researchers without a professional background can approach the interview without preconceptions [26], and can employ a certain naivety to encourage detailed

explanations from the informant. Their status as an "outsider" may, however, generate reticence or suspicion. In contrast, a fellow professional can harness prior understanding of the topic and the professional culture [27], and may be able to pursue issues more thoroughly by virtue of not having to seek explanations of basic terminology and concepts. He or she can also enlist feelings of professional cooperation and solidarity to encourage disclosure, and may gain informants' confidence more readily than a non-practitioner [28]. It may also be possible to explore sensitive issues or tap extreme or deviant views [14,16,29]. Chew-Graham et al. [14] report that access is easier when the GP informant knows the interviewer to be a clinician, and they also suggest that such interviews gave richer data. Moreover, Andersson et al. [13] suggest that shared knowledge and interest between the participants may increase the interviewer's credibility. A fellow GP may thus more readily elicit a "private" account [16].

In this study, certain advantages of a professional background did appear to operate. However, on occasions the interviewer's professional identity served to redefine the purpose of the interview. The study sought information on practitioners' conceptual and explanatory frameworks, yet this was sometimes translated into questions of factual knowledge and professional competence. For some informants, this gave rise to feelings of being under professional scrutiny. Other studies have suggested that the interviewer may be treated by his or her peer informants as an "expert" in the focus of the interview [14,30]. Chew-Graham et al. [14] also identified the notion of being under scrutiny, and in both their study and our own the interviewer's identity as a GP may have contributed to the feeling that the interview was a factual assessment of clinical knowledge – despite assurances to the contrary in our study. Again, the specific peer relationship seems to be central to this. If the interviewer had been a social scientist, there might have been no concern that such a person would test medical knowledge, since the social scientist would not necessarily have been perceived to know the correct answers. Accordingly, clinicians may respond readily to a non-clinician interviewer when questioned about their practice [26], whilst informants who feel they are being judged will be particularly cautious in conversations with a fellow professional [14].

Questions of professional identity may underlie many of the issues raised by this study. Constructing and maintaining a distinct professional identity is central to professional socialization [31], and this identity is often maintained through communication processes [32,33]. In an interview with a fellow professional the individual's professional identity is at stake, and steps are therefore taken to protect this identity. Concern with the status of one's professional knowledge, a certain defensiveness regarding one's practice, and a polite and positive attitude to the interview are all potential communicative means of sustaining a professional identity.

There is the possibility when interviewing one's peers of "conceptual blindness", whereby "the interviewer's own feelings and opinion about the field [may] govern the dialogue and interpretation" [13]. An allied issue is that familiarity of the "insider" with the area of study may dominate the process of data analysis [34] and prevent novel insights [35]. Obtaining sufficient distance from the topic being investigated may be problematic when interviewing fellow GPs [15,17]. In our study, the interviewer sought to address this issue through a reflexive approach to the study [36]. She utilized her clinical knowledge to frame appropriate questions and interpret the answers, whilst also attempting to remain attentive to ideas and interpretations that lay outside the familiar explanatory framework of medicine.

This study also highlights how interviewing one's peers challenges some traditional assumptions about the informant–interviewer relationship – that they are considered to be anonymous to each other, from different social groups, and unlikely to meet again [10]. A pre-existing or possible future professional relationship between interviewer and interviewee may affect the conduct of the interview and the data that result. The interviewer may therefore have to manage a combination of roles with regard to the informant: researcher and colleague [12].

Apparent equality of status in an interview between peers may conceal more subtle intra-professional hierarchies, which may influence the nature and process of disclosure. Structural differences, such as those of age or gender, will also operate separately from those of professional status. In this study, there were indications that the interviewer was seen by informants, on different occasions and even within a single interview, as professionally both junior and senior, and that the researcher–informant relationship differed across types of professional peers. This is likely to reflect, at least partially, differing perceptions of the relative "expertise" of the interviewer. Whether the informant and interviewer are from the same or different professions may therefore have somewhat different methodological implications, and should be considered when interviewing fellow practitioners.

This study also illustrates the reciprocity of qualitative interviews. The interview account is not simply "collected" from the informant but is

"co-authored" by both participants [37]. Rather than being one-way communication from informant to researcher, the interview involves a two-way exchange, in which both parties may ask questions [38]. Moreover, whilst ostensibly the interview has an agreed focus, each party may at times pursue other agendas. The interview is a social situation like any other, and displays what ethnomethodologists refer to as "reflexivity" – informants are concerned as much with achieving certain purposes (e.g. of self-presentation) within that situation as with providing a description of their beliefs or attitudes [39]. Even apparently "private" accounts are "social constructs, created by the self-presentation of the informant and whatever interactional cues are given off by the interviewer about the acceptability or otherwise of the accounts being presented" [40]. What informants say is conditioned by the broader social – and, in this case, professional – context of the interview, and by one party's assumptions regarding the other's role, status, and identity [41].

Certain factors may have restricted the insights emerging from the interviews on this topic. The time available for the interviews with working practitioners was limited, and most of this was devoted to exploring the primary focus of the study. Whilst asking informants directly about their experiences of the interview – rather than relying solely on the interviewer's perceptions – provides a new perspective on this topic, addressing the issue so explicitly may inevitably have encouraged socially desirable responses.

Nonetheless, this study highlights important methodological issues when conducting interviews with fellow practitioners. As an insider, the interviewer can gain potentially rich insights by capitalizing on a shared culture and a common stock of technical knowledge, as well as feelings of collegial trust. Conversely, a need to project a positive professional identity to a colleague may mould the informant's responses, especially when the objectives of the study bear upon professionally sensitive or contentious issues. Involving both a clinician and a non-clinician in the interpretation of the data may offset the drawbacks of either approach. Intrinsically, however, the insider's understanding of a professional culture is neither better nor worse than that of an outsider – the appropriate approach relates to the objectives of the study.

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References

[1] Jones S. Depth interviewing. In: Walker R, editor. Applied qualitative research. Aldershot: Dartmouth; 1985. p. 45–55.
[2] Arksey H, Knight P. Interviewing for social scientists. London: Sage; 1999.
[3] LeCompte MD, Schensul JJ, Weeks MR, Singer M. Ethnographer's toolkit 6: Researcher roles and research partnerships. Walnut Creek, CA: Altamira Press; 1999.
[4] Brewer J. Ethnography. Buckingham: Open University Press; 2000.
[5] Fontana A, Frey JH. The interview: From neutral stance to political involvement. In: Denzin NK, Lincoln YS, editors. The Sage handbook of qualitative research. 3rd ed. Thousand Oaks, CA: Sage Publications; 2005. p. 695–727.
[6] Morse JM. Interviewing the ill. In: Gubrium JF, Holstein JA, editors. Handbook of interview research: Context and method. Thousand Oaks, CA: Sage Publications; 2002. p. 317–28.
[7] Richards H, Emslie C. The "doctor" or the "girl from the university"? Considering the influence of professional roles on qualitative interviewing. Fam Pract 2000;17:71–5.
[8] Hoddinott P, Pill R. Qualitative research interviewing by general practitioners: A personal view of the opportunities and pitfalls. Fam Pract 1997;14:307–12.
[9] Hamberg K, Johansson E. Practitioner, researcher, and gender conflict in a qualitative study. Qual Health Res 1999;9:455–67.
[10] Platt J. On interviewing one's peers. Br J Sociol 1981;32:75–91.
[11] Finch J. "It's great to have someone to talk to": The ethics and politics of interviewing women. In: Bell C, Roberts H, editors. Social researching: Politics, problems, practice. London: Routledge & Kegan Paul; 1984. p. 70–87.
[12] Hockey J. Research methods – researching peers and familiar settings. Res Pap Educ 1993;8:199–225.
[13] Andersson SJ, Troein M, Lindberg G. Conceptions of depressive disorder and its treatment among 17 Swedish GPs. A qualitative interview study. Fam Pract 2001;18:64–70.
[14] Chew-Graham CA, May CR, Perry MS. Qualitative research and the problem of judgement: Lessons from interviewing fellow professionals. Fam Pract 2002;19:285–9.
[15] Prasad LR, Gantley MM, Underwood MR. Management of deliberate self-harm in general practice: A qualitative study. Br J Gen Pract 1999;49:721–4.
[16] Perry M, Chew-Graham C. Finding a vein or obtaining consent: A qualitative study of hepatitis C testing in GP methadone clinics. Fam Pract 2003;20:538–44.
[17] Lundh C, Segesten K, Björkelund C. To be a helpless helpoholic – GPs' experiences of women patients with non-specific muscular pain. Scand J Prim Health Care 2004;22:244–7.
[18] Westerståhl A, Björkelund C. Challenging heteronormativity in the consultation: A focus group study among general practitioners. Scand J Prim Health Care 2003;21:205–8.
[19] Hale LA, Pigott J. Exploring the content of physiotherapeutic home-based stroke rehabilitation in New Zealand. Arch Phys Med Rehabil 2005;86:1933–40.

[20] Petursson P. GPs' reasons for "non-pharmacological" prescribing of antibiotics: A phenomenological study. Scand J Prim Health Care 2005;23:120–5.

[21] Willems SJ, Swinnen W, De Maeseneer JM. The GP's perception of poverty: A qualitative study. Fam Pract 2005; 22:177–83.

[22] O'Flynn N, Britten N. Does the achievement of medical identity limit the ability of primary care practitioners to be patient-centred? A qualitative study. Patient Educ Counseling 2006;60:49–56.

[23] Burman E. Interviewing. In: Banister P, Burman E, Parker I, Taylor M, Tindall C, editors. Qualitative methods in psychology: A research guide. Buckingham: Open University Press; 1994. p. 49–71.

[24] Dey I. Qualitative data analysis: A user-friendly guide for social scientists. London: Routledge; 1993.

[25] Pope C, Ziebland S, Mays N. Analysing qualitative data. BMJ 2000;320:114–6.

[26] Iversen L, Farmer JC, Hannaford PC. Workload pressures in rural general practice: A qualitative investigation. Scand J Prim Health Care 2002;20:139–44.

[27] Odendahl T, Shaw AM. Interviewing elites. In: Gubrium JF, Holstein JA, editors. Handbook of interview research: Context and method. Thousand Oaks, CA: Sage Publications; 2002. p. 299–316.

[28] Aira M, Kauhanen J, Larivaara P, Rautio P. Factors influencing inquiry about patients' alcohol consumption by primary health care physicians: Qualitative semi-structured interview study. Fam Pract 2003;20:270–5.

[29] Hussey S, Hoddinott P, Wilson P, Dowell J, Barbour R. Sickness certification system in the United Kingdom: Qualitative study of views of general practitioners. BMJ 2004;328:88.

[30] Collins P. Negotiating selves: Reflections on "unstructured" interviewing. Sociol Res Online 1998;3. Available at: http://www.socresonline.org.uk/socresonline/3/3/2.html

[31] Broadhead RS. The private lives and professional identity of medical students. New Brunswick, NJ: Transaction Books; 1983.

[32] Apker J, Eggly S. Communicating professional identity in medical socialization: Considering the ideological discourse of morning report. Qual Health Res 2004;14:411–29.

[33] Lingard L, Garwood K, Schryer CF, Spafford MM. A certain art of uncertainty: Case presentation and the development of professional identity. Soc Sci Med 2003;56:603–16.

[34] Hamberg K, Johansson E, Lindgren G, Westman G. Scientific rigour in qualitative research – examples from a study of women's health in family practice. Fam Pract 1994; 11:176–81.

[35] Delamont S. All too familiar? A decade of classroom research. Educ Anal 1981;3:69–83.

[36] Grbich C. Qualitative research in health care: An introduction. London: Sage Publications; 1999.

[37] Kvale S. Inter-Views: An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage Publications; 1996.

[38] Oakley A. Interviewing women: A contradiction in terms. In: Roberts H, editor. Doing feminist research. London: Routledge; 1981. p. 30–61.

[39] Holstein JA, Gubrium JF. Phenomenology, ethnomethodology, and interpretive practice. In: Denzin NK, Lincoln YS, editors. Handbook of qualitative research. Thousand Oaks, CA: Sage Publications; 1994. p. 267–72.

[40] Dingwall R. Accounts, interviews and observations. In: Miller G, Dingwall R, editors. Context and method in qualitative research. London: Sage Publications; 1997. p. 51–65.

[41] Baker C. Membership categorization and interview accounts. In: Silverman D, editor. Qualitative research: Theory, method and practice. London: Sage Publications; 1997. p. 130–43.