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METHODOLOGY

Junior-to-junior research interviews as method for clinical practitioner-researchers

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Shaun Peter Qureshi[1]
Katharine Rankin[1]

Edinburgh Medical School, University of Edinburgh, Edinburgh, United Kingdom

Abstract: This methodological article argues for the advantages of trainee health professionals investigating their own work contexts through qualitative research interviews with peers and presents such junior-to-junior interviews as method. The usefulness and flexibility of the method are demonstrated through two vignettes based on the authors' individual experiences as junior medical doctors generating data through interviews with their peers. The article discusses specific considerations of junior-to-junior interviews: academic considerations including cognizance of reflexivity, trustworthiness, commitment, coherence; ethical considerations including hierarchy, confidentiality, support needs. The method has limitations including research being carried out by novices and on a small scale. However, we argue that junior-to-junior interviews allow for unique and valuable data generation, and encourage other practitioner-researchers to consider how this or similar methods may be integrated into research approaches across clinical disciplines, and organizational and cultural contexts.

Keywords: methodology, research design, reflexivity, practitioner-researchers, professional education

Introduction

For trainee health care professionals, undertaking research can provide opportunities to contribute to enhanced clinical care.[1] Furthermore, clinical trainees may feel disempowered in hierarchical and complex systems in which they work;[2] by undertaking research about their own work contexts, clinical trainees may have opportunities to investigate issues affecting their education and practice in a legitimized way. While undertaking such research, clinical trainees are practitioner-researchers, ie, undertaking systematic investigation relevant to the jobs in which they work.[3] This aligns with the notion of clinician-scientist, someone who works across both care and science, who must be able to access knowledge and think critically in differing ways.[4] Research carried out by practitioner-researchers may reduce any perceived disparities between "knowledge-creators and knowledge-users"[4(p570)] and, we argue, provide rich and unique insights that would not be otherwise achieved.

Building on this argument, this article presents the case for clinical trainees undertaking data generation with their peers through qualitative research interviewing. Throughout this article, we use the term "junior-to-junior" to describe this method of interviewing. "Junior" is purposefully employed to refer to health care professionals working in a training capacity. This is extrapolated

Correspondence: Shaun Peter Qureshi
Edinburgh Medical School, University of Edinburgh, 47 Little France Crescent, Edinburgh EH164TJ, United Kingdom
Email shaunpeterqureshi@gmail.com

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particularly from "junior doctor", used in the UK to describe working doctors undergoing postgraduate training, ie, having graduated from medical school but not yet fully trained specialty consultants or general practitioners.[5] It is commonplace for UK doctors-in-training – including the authors of this article – to identify themselves as "junior". Further ownership has been taken of the term "junior doctor" during recent controversies in medical training which led to strikes in the UK.[6] We emphasize therefore that "junior" is not a derogatory term, but for the purposes of this article used in a positive manner to refer to health care professionals in clinical training.

This article will begin by briefly explaining what we mean by qualitative research interviews and why the researcher is central to data generation. We will then each introduce our own current research as examples of how junior-to-junior research interviewing can provide effective means for addressing research questions. This article will then discuss academic and ethical considerations particular to this method, including the practical implications these have, and the limitations of junior-to-junior interviews.

As far as we are aware, this is the first article to describe and clearly elaborate on junior-to-junior interviews as we describe them in the health research literature. Junior-to-junior interviews could be viewed as a form of peer interview, the value of which in social research has been previously acknowledged.[7] Peer interviews are generally described as those in which a researcher utilizes someone else, relevant to their area of study, to carry out interviews and provide data for the researcher to analyze. The advantages and disadvantages of peer interviewing have been well documented in the literature[8] and are well summarised by Byrne et al in their research regarding the experiences and perceptions of medical student interviewers and interviewees from a single institution.[9] They describe potential benefits to the researcher and to the research, as well as the wider academic institution. They also present academic considerations including familiarity between interviewer and interviewee leading to shared understandings – but also risking unquestioning acceptance of implicit concepts; practical considerations including the need for training of inexperienced interviewers and the time required to do this. They express a wish to have screened interviewers and evaluated their competence – however, they were unable to do so due to time constraints.[9]

Others have also identified concerns that the level of skill and resources required limits the usefulness of peer interviews.[10] This may make it more practicable to have the researcher carry out the interviews her/himself. Here, we are promoting junior-to-junior interviews as a method in a research process where the same researcher-practitioner designs the research, carries out the interviews with her/his peers and analyses the findings.

Similar academic and ethical challenges regarding the peer status of the researcher may remain and these will be discussed. However, there may also be additional academic benefits to the researcher also undertaking the data collection – as in the method we present. In the peer interview process, the researcher is separate from the data generation and reliant on the interviewers' ability to identify and follow up on relevant themes, clarify meanings or elicit expansion on interesting points. This potential disconnection is not present in the method we propose here. However, a significant degree of transparency regarding the researcher's preconceptions and foregrounding may be required if they are undertaking both data generation and subsequent analysis – demanding careful reflexivity and lending further complexity to the research process.

We hope that this article will encourage other junior health care professionals to consider how they might study their own contexts and stimulate discussion of methodological considerations for this study.

The interview

Several approaches to research interviewing exist (eg, positivist, realist, postmodern),[11] making it necessary for us to clearly explain what we mean by and how we conceptualize research interviews in this context. This article concerns in-depth, semi-structured interviews, which are distinct from structured interviews and questionnaires. Through qualitative research interviewing, we aim to study the phenomena experienced by participants, meanings of these phenomena to participants, and accounts of how these phenomena came to be.[12] The semi-structured interview allows the researcher to use her/his starting understanding of the area of research and appraisal of the existing evidence to develop a flexible set of questions or themes to prompt responses. However, each interview participant will respond in open-ended and idiosyncratic ways that cannot be anticipated. Further valuable questions to ask must be defined by the interviewer and the participant during the process of the conversation and cannot be

fully predicted in advance.[12] Every interview will be different and cannot be reproduced identically.

This view of data generation through interviews is at odds with the objectivist view of research in which we had been immersed during our clinical training. Our view is that as the interview progresses, we are not uncovering objective truths that were waiting for a researcher to reveal them. Instead, the interviewee and interviewer are participant-observers in the production of data[13] and collaborators as meanings are co-constructed.[14] Transitioning from the objectivist lens which is dominant in clinical sciences, and the interpretivist lens of qualitative research, has been described as health care professionals "learning to think qualitatively".[15]

We agree with Brinkmann and Kvale's[12] view that qualitative research interviewing is a craft that is irreducible to strict rules. In learning to carry out interviews, it was necessary for us to each hone our craft. We are medical doctors who are experienced interviewers of our patients for information gathering, and also the questioning of students as testing of knowledge to stretch themselves as learners. However, there is a significant distinction between these forms of questioning and qualitative research interviews. In our junior-to-junior interviews, we are not asking participants to provide information in a matter-of-fact manner, nor are we seeking a "correct answer". We do not wish for participants to feel they need to seek our approval nor conform to give expected responses, but for them to speak openly about their unique experiences, opinions, and feelings. We, therefore, adapted our approach so that questions were worded out of a genuine curiosity to learn the answer.[16] Our attitude is to approach the interview as the learners in the scenario and with our participants as experts on their experience.

Employing junior-to-junior interviews

Having established the central importance of the researcher to data generation, here we will make the case for the usefulness of data generation that occurs during junior-to-junior research interview studies. By presenting the examples of our own experience, we aim to demonstrate that junior-to-junior interviews are flexible and adaptable, and how different researchers, research questions, and/or methodologies may still usefully incorporate this method. The vignettes are included as examples and do not exhaustively describe every methodological and ethical consideration from the respective studies. Significant overarching methodological and ethical considerations are considered in the relevant sections later in the article.

It is important not only to consider what is happening during the interview, but the wider historical and cultural context in which it takes place. Therefore, to introduce the vignettes, we provide some information about the context in which we are working and studying.

Context

In the United Kingdom, medical undergraduates follow a 5–6-year undergraduate curriculum. Medical graduates then enter a 2-year general "Foundation" training programme as qualified doctors, before typically entering 3–8 years of advanced or specialist training which leads to certification as consultants or general practitioners.[17] In recent years, the morale of the medical profession in the UK appears to have reached a nadir.[18] In 2012, 28% of the Foundation Year 1 doctors screened positive for pathological anxiety in a large online survey.[19] On the background of an increased focus on profit and productivity alongside increased media scrutiny and an increasingly litigious work environment, a large-scale postal survey of 2000 doctors carried out in 2017 found that 92% thought that working conditions in UK hospitals had deteriorated in the past decade.[20] Well-publicized disputes regarding junior doctor contract negotiations resulted in landmark junior doctor strikes in 2016. These brought these issues to the attention of the public, and the disputes provided an outlet for the pre-existing unrest and dissatisfaction of junior doctors.[6]

There are few well-conducted, longitudinal studies that aim to answer the question of why morale appears to be worsening.[18] Most of this literature is questionnaire-based: quantitative in nature and attempting objective measurement of the intangible concepts of burnout, dissatisfaction, and stress. The adoption of this approach is understandable; it allows population-based data-collection and follow-up of trends in consecutive cohorts. However, this is a complex and multifaceted area and there is value in also undertaking qualitative research in order to enrich and augment this body of literature, and more deeply understand the junior doctors' experience.

Vignette 1 (SPQ)

In postgraduate training, junior doctors learn to deliver care "on the job", and therefore learning is inextricably linked to practice in the workplace. I am investigating

experiences of newly graduated doctors learning to care for patients approaching the end of life in the acute hospital setting. My own experiences as a junior doctor informed every aspect of this research, including, in the first instance, my recognition of the importance of studying this topic. I have insight into the key role junior doctors play at this time in patients' lives and knew that by interviewing junior doctors, data could be generated which would usefully increase understanding of the challenges faced in their learning. My understanding contrasts with that of non-medical colleagues, who were unaware and surprised this care fell under the remit of junior doctor's work. In fact, junior doctors care for dying patients from the point of graduation, and it is they who spend most time in the wards with acutely ill patients and with the dying.[21]

Care provided by junior doctors is affected by workplace factors out with their control including shift patterns which are often disjointed and anti-social, and lack of continuity of care.[22] For example, junior doctors are often called to review patients at night with no senior medical support immediately available and may feel under pressure from nursing staff and patient and their relatives. I am aware of the complex questions raised by these situations from my own practice – how far to go with certain treatments; at what point may a person be considered as dying; whose responsibility it is to make these assessments; the difficulty learning to understand, articulate, and answer these questions. My aim for this research was to have an emancipatory focus: to give voice to my peers working in these circumstances, and inform the work of policy makers and educators.

The interview questions were devised following assimilation and appraisal of the existing literature. Furthermore, reflections on my own experiences as a junior doctor influenced the questions which were selected. My appreciation of the difficulties faced in this area informed the course of questioning during interviews, allowing me to frame the interview as a conversation between peers. The topic is a sensitive one, and participants potentially felt vulnerable and exposed. Participants discussed experiences of when they did not know what to do and instances where patient deaths may have been emotionally distressing. It was essential that one-on-one confidential interviews were carried out, in a private, non-clinical environment, and data were anonymized. The interviews gave participants the opportunity to discuss their experiences, and feelings about them, in a space where they could be honest and feel listened to. This was a unique experience for many of them, because – as emerged from the interview data – during the normal working day, junior doctors may be seen as only there to perform menial tasks, and their views may not be invited or valued. Participants told me they appreciated the freedom to speak about their insecurities and areas where they lacked understanding, as well as speak critically about their training programme and trainers. Although this was a potentially cathartic experience, it was not appropriate for me to offer emotional support or guidance. Participants were offered optional pastoral and professional support from medical doctors not linked to the study.

As the data collection process progressed, questions were refined in order to further explore useful ideas and for emerging themes to be further developed, challenged, or nuanced. The data generated, and themes emerging from my analysis, are unique and would be different had someone else done the research. Furthermore, this study has been carried out on a small scale in one part of the UK. However, I argue that the findings have relevance to other settings (ie, transferability).[23] This includes having recruited participants who are undergoing a national clinical training and working in a health system which is common across the UK and encountering clinical situations in common with other junior doctors.[22] Findings will, therefore, be of value to compare and contrast to practice in other settings. Despite this transferability, I neither can nor wish to make claims to generalizability of my findings, but aim instead to reason inductively, and lead to a theoretical explanation for phenomena under study.[24]

Nevertheless, I was conscious of reflexivity, for the trustworthiness of the research to be maintained (as will be discussed in more detail later as an academic consideration). In data generation and analysis, I was aware of my own views and strove not to impose on to the experiences of others. In order to achieve this, I maintained a research journal about my personal opinions on the area under study and immediately documented my thoughts and feelings following each interview. Doing so allowed me to reflect on why I responded in certain ways and become further aware (and wary) of my own assumptions. For example, I remembered many instances from my experience where I felt that constraints within a hierarchical system impeded good patient care and training. Data from some interviews reflected similar perceptions, although other participants did not feel that hierarchy

negatively affected their experience, which I initially found surprising. By being open to having my preconceptions challenged, I have been able to interpret the data in a more trustworthy way: although medical hierarchy was perceived by all participants, it was not always experienced in the same way.

Vignette 2 (KR)

My doctoral research involves an exploration of the experience of trust in the clinical domain – particularly from the perspective of newly qualified doctors. I wish to explore my participants' interpretation of their experience and therefore employed interpretative phenomenological analysis (IPA) as described by Smith.[25] Rather than make claims about the objective nature of the reality of entrustment, I aimed to approximate an understanding of the individual's subjective experience.

IPA is an idiographic approach, primarily concerned with the individual.[26] I interviewed four participants using semi-structured junior-to-junior interviews. This method of data collection was chosen to be consonant with the intimate focus of IPA. Participants had the opportunity to speak freely and reflectively. This allowed flexibility in the dialogue with questions being modified in the light of participant's responses. When unexpected areas were highlighted, they could be further explored. This approach takes longer to carry out than highly structured interviews or questionnaires, permits less control over the situation, and is likely to be more challenging to analyze.[22] However, it was chosen in the hope that it would generate the richness of data demanded by IPA. Interviews were also chosen in preference to focus groups. This is not only because the process could potentially uncover some difficult and private topics for the interviewees but also because it may be substantially more difficult to adhere to our idiographic principle.

My own experiences as a junior doctor meant that I felt well placed to try to understand and bring to the fore the essence of my participants' experience. They have also undoubtedly influenced every part of this research: from conception to completion. The recollections of my own experience of "being trusted" – or indeed feeling that I was not trusted – as a newly qualified doctor are vivid and range from very positive to extremely negative. This is certainly part of the reason for my choice of subject area and influenced how this research was framed. The sense of a shared understanding allowed for fruitful discussions with participants, richly evidenced by vivid anecdotes. It allowed the conversation to evolve organically, as it would with a colleague. It was, however, important for me to acknowledge my potential biases and consider how these may be affecting my steerage of the interview and phrasing of questions. It was also important to acknowledge that I am ultimately part of the medical hierarchy and that this may have an impact on how my participants responded to me. IPA accepts that the researcher has a dynamic and active role in the research and that the experience and assumptions that they bring to the development of the research and interpretation of results must be acknowledged and discussed reflexively. Descriptions of theoretical orientation, personal values, and assumptions were recorded in advance, and detailed field notes were kept during the data collection and analysis phase. Immediately after one of my interviews was complete, we debriefed quickly over how we thought it had gone. I explained that I had been particularly worried that participants may be less open with me about finding their job challenging or difficult. However, my participant offered a different opinion on this. He felt that our shared understanding of the structure and culture let him talk more openly. He encapsulated this effect when he said he "wouldn't have told a career researcher half of that."

Considerations

We will now introduce academic and ethical considerations of the junior-to-junior interview method. Where relevant, we will make clear the practical implications these considerations are likely to have on a study. There are several resources available which discuss considerations for qualitative research interviewing in general; therefore, we will discuss only those considerations particular to the junior-to-junior interview method.

Academic considerations

It is important to consider the implications of junior-to-junior interviews from an academic standpoint. For example, participants may feel able to talk in medical shorthand and utilize jargon without pausing to explain themselves. Talking in this shared language may allow participants greater fluency and to give detailed illustrative examples of their experiences. However, this assumes a level of interpretation on the part of the researcher – which opens up some important considerations.

As a medical practitioner, the researcher will have personal experience of being a junior doctor. Therefore, they will inevitably have their own opinion about this

phenomenon. This experience and the resultant foregrounding will influence the whole research process. If we accept that both the researcher and the research subject are social, meaning-making beings embedded in context and bounded by time and place,[27] it becomes imperative for researchers to consider how their existing preconceptions and inescapable biases might influence the research process.[28] Being reflexive allows us to manage our presuppositions consciously.[29] Reflexivity is the notion of examining how the researcher and intersubjective elements impact on and transform research[30] and is a multifaceted process.[31,32] Gough describes it as "at the very least" implying that "researchers make visible their individuality".[33]

When viewed in this way, the subjectivity inherent in being reflexive can be transformed from possible limitation into valuable opportunity.[30] Rich insights can be realized by considering the researcher an active agent in the research process, examining their personal responses and interpersonal dynamics.[34,35] Potential power imbalances between researcher and participant – such as the one between two junior doctors at different stages in training – can also be acknowledged and addressed.[36] Transparency regarding the authors preconceptions allows the reader to evaluate the research process, methods, and outcome.[37] This allows appraisal of the fit between the data and the authors interpretations; also allowing readers to conceptualize possible alternative meanings and understandings.[38] It also enables scrutiny of the integrity of the research through offering a methodological log of research decisions.[39]

In our positions as junior doctors interviewing junior doctors, being reflexive is of paramount importance. Practically, this may be achieved through the use of reflexive diaries and detailed field notes. In this way, descriptions of preconceptions and theoretical perspectives can be recorded and their potential impact considered. Maintaining a reflexive log throughout also allows the researcher to give a transparent and reflexive account of the processual nature of their research. This transparency may also be aided by detailing the data collection process and the rules used to code the data. In practical terms, this may involve providing textual excerpts and examples of the analysis.

Quality control issues in this type of research have been described by Elliott et al[38] and Yardley.[40] Rigour of qualitative research is described as depending on the completeness of the data and analysis. This partly depends on being able to demonstrate the completeness of our analysis through practical strategies such as credibility checks with another researcher looking at the data, triangulation strategies and situating our sample by describing our participants and their life circumstances (in a non-identifiable fashion). It also partly depends on sample adequacy – not necessarily in terms of participant numbers but in terms of ability to supply information for a comprehensive analysis.[38] Being a junior doctor looking to interview other junior doctors may have a practical advantage here. We may be able to utilize our insider knowledge to focus our recruitment strategy on the groups of people who we feel will be best situated to generate comprehensive data on our subject of interest. We may also be able to capitalize on our insider status to obtain recruitment opportunities with the population from whom we wish to sample – for example, junior doctor teaching.

Further quality issues in this type of research include those of commitment and coherence. Commitment refers to a prolonged engagement with the topic, immersion in the data, and the development of relevant methodological and interview skills: coherence refers to the clarity and consistency of the research question, methodological choices, and philosophical perspective.[38] These academic issues can prove practically challenging for any novice researcher. In the case of junior doctors, they are significantly more likely to be familiar with post-positivist paradigms and this type of research, therefore, requires a shift to an entirely new way of considering reality. For example, many junior clinical practitioners may never have heard or used the terms "ontology" or "epistemology", let alone have a functional understanding of them. Developing this requires a substantial commitment in terms of time and academic effort. This may be taxing if research is undertaken alongside a demanding clinical career or on a finite timeframe whilst out of a postgraduate training programme. Similarly, if the research demands an ongoing relationship with participants, the nature of junior doctor rotations and working patterns can make this difficult to achieve.

If significant consideration can be given to these academic issues of quality, then junior doctors are well placed to produce insightful and impactful research on the experiences of junior doctors. Their shared understanding is likely to result in a convincing and meaningful account of the subject phenomena, which resonates with the experience of being a junior doctor.

Ethical considerations

There are specific ethical considerations for junior-to-junior interviews. We seek to generate data with our colleagues about the systems in which we work, and as we will explain the participants are in a vulnerable position. Consideration must be given to this throughout the research process. At the recruitment stage, it must be noted that potential participants are busy people with multiple commitments, eg, junior doctors required to attend to their clinical commitments while on duty, then, when off duty, meet the educational requirements of their postgraduate portfolio and study for postgraduate exams. Medical training can be perceived as a hierarchical and competitive structure,[41] and careful consideration must be given to recruitment so that participants do not perceive they are under pressure to take part. The researcher–participant relationship can already provide a power imbalance in favor of the researcher, and we consider it good practice to limit this imbalance as much as possible. In practical terms, this may mean that it is not possible to recruit participants with whom the researcher works directly in the clinical environment, and especially not those with whom the researcher has managerial or supervisor responsibility. This can provide difficulties if working in more rural geographical locations, where the clinical community is likely to be small and work closely together. In previous qualitative studies, medical students have expressed worry about showing anxiety or concern; perceiving it as a show of weakness that can be potentially stigmatizing for their future career.[42] In recruitment to junior-to-junior interviews, it should be emphasized that participating will not affect clinical training or employment.

The time and place of interviews should be planned thoughtfully and should not be carried out at times when participants are likely to be excessively tired, which may have effects on the participant's wellbeing and also patient safety. This will involve the researcher being flexible to accommodate the clinical rota commitments of the participant.

During the consent process, participants must be given the opportunity to make informed decisions about whether or not to participate, having the advantages and disadvantages of taking part clearly explained. The only direct benefits to the participant are likely to be the satisfaction of having contributed to the research and the opportunity to have their voice heard. It may be cathartic for the participant to share their experiences, although, the researcher should listen, s/he is not there to provide clinical, career, or personal advice or guidance. The main disadvantage for participants is the time and effort asked of them when their time is already limited. However, there is also the potential for them to become upset by matters discussed. It is appropriate to plan for this contingency by organizing for a professional separate from the study that participants may go to for confidential support.

Maintaining confidentiality and anonymity of participants is vital. Participants must feel free to speak honestly and critically without fear of repercussions in order to generate fruitful data. Participants must understand that data and the results of data analysis will eventually be available to others, but their identity will not be revealed, and the details of individuals who participated in this study will not be divulged. In the case of junior doctor participants, we emphasize that we are not going to report them to training programme directors or educational supervisors on the basis of what they say. However, there is a caveat which concerns patient safety and our ongoing duty of care toward patients: it is essential for participants to understand that if they reveal information which raises significant concerns about patient safety that this concern will need to be escalated to appropriate authorities within the organization, which will likely result in their identities being revealed to whomever is necessary. This may have an impact on what they are comfortable to share. Furthermore, the importance of confidentiality may preclude the use of junior-to-junior in smaller clinical settings, ie, if there are a limited number of potential participants, maintaining anonymity becomes more difficult. Careful consideration must be given by the researcher to how (or if) confidentiality can be ensured to her/his specific context.

As with all research, it is also necessary to be conscious of potentially detrimental effects to the researcher.[43] There is potential for being emotionally affected by the interview process, particularly as junior-to-junior interviews will commonly involve discussion of matters with which the interviewer can greatly relate and empathize. The need for self-care throughout the research should also be considered, including a means of de-briefing with colleagues for support in a way which does not undermine confidentiality.

We have highlighted some of the key ethical considerations particular to junior-to-junior interviewing. Study timelines should accommodate time for addressing these

ethical considerations, and applying for and progressing with local research governance and ethics committee approvals. As with all research, in deciding if and how to progress with a junior-to-junior interview study the benefits of the research must be balanced carefully against the potential harms or risks.

Potential limitations

Research undertaken utilizing junior-to-junior interviews must consider potential limitations of this method. One major limiting factor is the impossibility of excluding bias. There may be selection bias, as participants who volunteer may be those with extremes of opinions which are not necessarily reflective of the norm. Bias may also arise from participants who withhold information or do not provide true accounts of their experiences, perhaps out of feeling vulnerable or fearful of being reprimanded for insufficient clinical knowledge. We do not believe it is the purpose of the interviewer to ascertain the truthfulness of their participants' accounts or whether an individual's experience is reflective of those of rest of their population. Instead, we are searching for valuable meanings across the data, aiming to build an authentic picture of the participant's perspective,[44] while knowing data generation and interpretation will inevitably be subjective.

This is particularly important to explain because of our clinical backgrounds, where we work alongside knowledgeable clinicians who are grounded in a post-positivist tradition. In our experience, the expectations from medical colleagues are that we will present an argument that our research findings fit quality criteria for quantitative clinical research, eg, generalisability, objectivity, reproducibility. On the contrary, we argue the researcher is a part of the social world under study and must be aware of her/his own biases, values, and preconceptions, rather than pretend that bias does not exist.[16] The trustworthiness of our work relies on the transparency, honesty, and professionalism of the researcher. We may make an argument for why we consider our findings transferable, but ultimately the burden of assessing how far our findings are relevant to other contexts rests with the reader.

One further potential criticism is that, by the nature of the method, junior-to-junior interviews will be carried out by novice researchers. It is essential to seek out and consult with expert qualitative researchers and methodologists to support the work. This can be more difficult with our background, situated in a community of clinical practitioners, and may take time and perseverance. However, this is necessary to ensure the research is academically robust and that we receive appropriate research training.

Further limitations include the question of the perceived usefulness of studies using junior-to-junior interviews, ie, how much valuable difference may result from relatively small-scale studies such as those described. In this article, we have discussed interviews with one group of participants, however, multi-perspective interviews may be carried out with more than one group yield rich insights.[45] For a thorough investigation, interviews may form only one part of a larger process of inquiry and may complement other methods, including quantitative studies.[46] Indeed, interviews may work well alongside observations as part of an ethnographic study. The challenges for junior doctors to carry out qualitative observations in their work environment would provide further barriers, which may make this impracticable. We argue that junior-to-junior interviews have value even as the sole method of data collection to contribute to a body of academic knowledge and give voice to practitioner training experiences.

Discussion

This article has presented our perspective that the researcher is integral to every stage of the research process and that qualitative research interviews exemplify the significant influence of the researcher on data generation and analysis. Junior health care professionals are well placed to devise research questions which will be of value to study about their own contexts. Junior clinicians should be empowered to take on the role of practitioner-researchers, and engage in studies employing junior-to-junior interviews with peers, to generate valuable data and results which would not otherwise be possible.

In the examples we have provided from our own experiences, we have demonstrated how the junior-to-junior interview method may be used by different researchers to address different research aims. In the first vignette, SPQ described utilizing this method to explore experiences of junior doctors learning to care for patients approaching the end of life in the general hospital. Junior-to-junior interviews allowed him to co-construct data with the participants and identify themes related to the workplace factors which influence the learning and practice of participants. In the second vignette, KR has described how junior-to-junior interviews facilitated access to participants' unique experiences of being entrusted in clinical practice – access which may have been more challenging

to achieve without the shared understanding between researcher and participant. This has allowed the development of a detailed, idiographic, and interpretative account of their experiences – consistent with the goals of IPA.

Being an insider to the processes under study is advantageous, but also brings challenges that must be considered. We have presented both academic considerations, including those of reflexivity and transparency, and ethical considerations, including issues of vulnerability and patient safety, and made suggestions of practical effects these may have. Furthermore, we have discussed real or perceived limitations of junior-to-junior interviews as method and provided responses to these being raised as potential criticisms.

This article has not considered research interviewing generally, but only in the context of junior-to-junior interviews. We have therefore focused specifically on considerations necessary for the premise of this article. This article is limited in that its perspective has been informed largely from the perspective of medical doctors, without other health care professionals. Indeed, the term "junior-to-junior" has been developed from common vernacular among medical doctors. We welcome research-practitioners from other professional groups to adapt this term as appropriate if they do not find it sufficiently inclusive. We believe this adaptation should be undertaken by researchers from other areas of practice, as we are not in a position to presume what language may be of greater relevance to them. Nevertheless, we believe that the concept represented by the term "junior-to-junior" interviews is transferable across clinical disciplines and have tried to explain how our identities as junior doctors have influenced our own studies so that readers might be able to consider their own experiences as practitioner-researchers may affect their approach to interviews. Furthermore, this article has considered the perspectives of only two practitioner-researchers. It is our hope that this article will instigate a conversation about this method, and we would welcome other researchers (from across clinical disciplines) to further build on or counter-argue with what we have presented.

One further limitation of this article is that the perspectives of only British practitioner-researchers have been considered. The training environment in the UK for junior doctors has been particularly difficult recently, making it a prudent time to utilize junior-to-junior interviews in research. Although we are UK medical doctors, we believe that our principles could be transferred to other settings and there will be many research questions which could be addressed using junior-to-junior interviews. Again, we would encourage other researchers to consider how a similar approach may be relevant to their context. We suggest that other potential examples of areas of study in which junior-to-junior interviewing may generate unique and valuable data include recent issues affecting new medical graduates in Canada[47] and Australia.[48]

In conclusion, we believe that junior-to-junior qualitative research interviews provide a useful method to generate valuable data about areas of study relevant to trainee health professionals. We are grateful to our peers who have participated in our research and shared their experiences with us, allowing us to carry out unique research and come to findings we believe would not have been otherwise possible. We encourage other trainee health care professionals to act as practitioner-researchers and to consider research using junior-to-junior interviews as method. We look forward to reading about how this or similar methods are integrated into the approach of practitioner-researchers across clinical disciplines and across different organizational and cultural contexts.

Disclosure

The authors declare no conflicts of interest in this work.

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