Wearing two hats: interviewing older people as a nurse researcher

Lorraine Ritchie

lorraine.ritchie@otago.ac.nz

ABSTRACT

Interviewing older people is a common practice in qualitative research. Interviewing older people as a nurse who is a researcher is also not uncommon. But what is the relationship between the two roles of nurse and researcher and is there a ‘correct’ approach? Researchers listen to people in an interview setting in order to collect data; nurses listen to people to take a history, a clinical assessment towards a plan for the delivery of care. How compatible are these two approaches to interviewing?

In this paper I explore the process, potential and actual tensions and particular challenges presented by the nurse-as-researcher interview with older people, using secondary analytic techniques to revisit and critique interview data collected as part of a doctoral research study exploring older people’s medication beliefs. The central themes I identify from these ‘double duty’ interviews relate to older people’s perceptions and expectations of the interview process, as much as to the interviewer’s conduct. I go on to consider the contextual features of the older person/interviewer interface which may impact on the interview: notably gender, age, commonalities and cognitive and physical abilities. Finally, I reflect upon how these role complexities which are inherent in the qualitative interview serve to strengthen my approach as a novice interviewer thus confirming the value of reflection.

Introduction

In this paper, I reflect on the process and particular exchanges within the clinician-as-researcher interview. The data on which the paper is based are taken from a wider research study into the medication-taking beliefs and practices of twenty older people in two small New Zealand towns. The current paper focuses on a secondary analysis of these data, where the role of the researcher as nurse is closely examined within the interview. As I am a registered nurse with a clinical background which consists primarily of nursing older people, I stepped into research interviewing (as opposed to clinical interviewing) as a relative novice in common with many postgraduate students. In this paper I share some of the reflections which this transition raised for me, and which are likely to have resonance for other clinicians in similar ‘first time’ situations.
Background

The primary research on which this paper is based emanates from my doctoral research into geriatric comprehensive assessment with a special focus on medication narratives. In the main study, twenty older New Zealanders (aged 67-92 years) were recruited from a larger local District Health Board study which was trialling the use of the InterRAI Minimum Data Set – Home Care (MDS-HC) assessment tool with older people living in the community (Keeling et al. 2005). Mediation is one of the domains of this tool and as I have an interest in beliefs around medication-taking, I interviewed all twenty participants in their homes about their medication within a fortnight of their initial assessment interview. My main interest was in asking the participants how they felt about taking medication; what it meant to them, and how they incorporated medication-taking into their everyday routines. This interest arose from previous home visits to older people where I had observed indifference, nonchalance and chaotic medication-taking routines and because in existing research emphasis has been placed less on patient beliefs in taking medicines (Britten, 1994), than on the ‘problems’ of non-compliance and polypharmacy in older people. I felt that asking people about their underlying feelings and attitudes towards taking medication might be of benefit in understanding their medication use.

Research approach and interviewing

The wider research study, and indeed the smaller reflection-focused study presented in this paper, employed a qualitative narrative approach. Qualitative research encompasses a range of methodological techniques with no one underpinning philosophy or perspective, although the subjective lived experience of participants is always valued. My research is underpinned by the philosophical position that knowledge is socially co-constructed through relationships with others. The constructionist-interpretive paradigm recognises multiple meanings and subjective realities (Finlay and Ballinger, 2006). Therefore with a philosophical position of valuing subjectivity, stories and the lived experience of older people, I employed a narrative approach to collection and analysis. In narrative studies, participants’ stories are particularly valued, and interviewing is the vehicle to obtaining the narratives (Riessman, 2008).

Qualitative interviewing emphasises depth and richness of response rather than the ability to compare and measure responses (Elliott, 2006). Standardisation and the same information were not being sought from each respondent, but rather ‘representations’ (Opie, 2003). My interview style was ‘semi-structured’ in that I had a question guide which I hoped to cover, but did not mind if the interviewee’s narrative digressed from this, as a narrative approach assumes that all narrative which arises from the interview is worthy in itself. In support of this theory and as an extension of this idea, Oakley (1981), in her classic paper, 'Interviewing

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2 InterRAI is an international network of researchers and health and social care professionals who promote the use of evidence-based practice in the care of older people: http://www.interrai.org/section/view/.
Women: a contradiction in terms’, dismissed the objective, value-free, researcher-distanced style of interview. She claimed that researchers cannot arbitrarily remove themselves from the interview context, and indeed ought not to. Holstein and Gubrium (2003: 4) agree that interviewers ‘are deeply and unavoidably implicated in creating meanings that ostensibly reside within respondents’.

Further, Oakley (1981: 58) does not see ‘personal involvement’ in the interview as a ‘dangerous bias’ but as a ‘condition under which people come to know each other and admit others into their lives’. As well as becoming involved in some of the clinical/health aspects of interviewees’ lives, which is the focus of this paper, at times I disclosed details of my own life with interviewees such as my job, what my research study was about and alluded to parallels with my ageing parents, where I thought this appropriate. Despite having provided a detailed Information Sheet, only one participant asked me further questions about what the study entailed. I was surprised at this and spent some time in the interview explaining this as this participant seemed to have a genuine interest which I hadn’t come across before. Another of my participants asked me ‘is this the sort of thing you want?’. Van Hoonoord (2005) describes a similar experience in her paper titled: ‘Am I doing it right?’: Older widows as interview participants in qualitative research’. Van Hoonoord found that participants were very concerned that they were giving her the ‘right’ information, even while telling her their own personal story about the experience of being a widow.

Interviews will always vary according to the profile of the participant group: their background, education level, gender, knowledge of research will all influence their responses and the relationship which ensues between researcher and participant (amount of shared story, disclosure). In particular, having something in common (such as coming from the same town or country or having shared similar life experiences or interests) can influence the direction and tone of an interview. For example, as a nurse I have recently interviewed a group of peers in an unrelated study - other nurse academics. We speak the same language; we are similarly acculturated into the world of professional nursing and the values and attitudes that lie therein (often invisible to outsiders). The interviews I conducted with these men and women had a different starting platform to those which I analyse in this paper where the participants were older people, strangers in the sense that I had not met them before. Despite this, I still found some common ground with two participants in the doctoral interviews: with one who had been a nurse and another who had been a general practitioner. I found that this commonality of medical backgrounds influenced the way we spoke to and understood each other, particularly about medication. Conversely, there were participants with whom I felt I had very little in common, interestingly, due to their life circumstances and outlook more than their age or gender.

As the ‘underlying rules’ (Cunningham-Burley, 1985: 67) of the research interview have evolved, how researchers position themselves is now being accepted in large part as fluid and contextual, although proper ethical boundaries and principles such as confidentiality, informed consent and so on must always be maintained (MoH, 2006). For a novice researcher/interviewer, appropriate ways to interview are not always clear, despite conducting pilot interviews and discussing the process with supervisors. In a sense, an important way to learn ‘how’ to interview and to feel at ease doing it, is by doing it. Many textbooks give advice as to the mechanics of the interview, but there is less written on the dynamics which take place in the interview. Robertson and Hale (2007) have written about distress in interviewing older people as painful topics may emerge. However, my doctoral interviews were about taking medication, which I felt was a relatively ‘safe’ topic as my questions were not about highly personal aspects of the participants’ lives, although I recognised that a researcher can never anticipate precisely what the conversation may bring up for people. In this paper I explore the tension for the researcher between being a clinician and a researcher, and the events and exchanges that are played out on this role boundary. It is acknowledged that related tensions around wanting to help, inform, reassure, sympathise, advise and
advocate for people may also occur for the non-clinical researcher. However, the clinician-researcher learns these features as an inherent and embedded part of their professional responsibility and duty. It is part of their training to administer help and so any role tension may therefore be a more acute one. Part of the learning and reorientation involved in doing qualitative research is to see the interviewee as person before patient.

Interviewing older people

In New Zealand, official government documents such as the Health of Older People Strategy (MoH, 2002) consider that ‘older people’ are those aged 65 years and over, which is the population group of this research. The question arises as to whether interviewing older people is any different to interviewing people of other age groups? Truglio-Londrigan (2006) writes of the challenge of establishing trust with older people due to their vulnerability, although vulnerability is not exclusive to older people and many groups could be considered vulnerable such as children, people with physical or intellectual disability.

Potential vulnerabilities of old age include sensory deficits such as hearing loss or visual impairment and other possible challenges such as dependence on others, social isolation, illness, institutionalisation and being at risk for functional decline (Wenger, 2003). Jonkinen et al. (2002) suggest that some older vulnerable people may need ‘extra protection’ around ethical issues such as consent, particularly if cognitive changes are apparent. While these particularities and cautions of interviewing older people are valid and have been well documented, it is important not to patronise older people and expect that all will require special attention, as not all older people are the same, and as Wenger (2003: 113) writes ‘there is no one recommended approach to interviewing older people across such differences’. For some older people the interview may be a welcome social occasion - a situation where they feel they are making a contribution, and that their knowledge and opinion is being listened to and valued. Manderson et al. (2006: 1322) write that the age of both the interviewee and the interviewer is significant and can influence the shape of the interview. In their study on the social dynamics of the interview, they found that ‘older interviewers often drew on life experiences to frame tentative or complex questions’ and ‘adopted a more conversational style’ than younger interviewers.

The results of this secondary analysis of my research did not indicate that my age, gender or social background might have impacted upon participants. However, the data below do indicate that my professional persona of nurse had some influence on the interview relationship. There is also the possibility that my being overt about my clinical background (through the wording of the Information Sheet for example) could have hindered and limited the scope of the research in some way, and I may have gained different data had I not gone into ‘nurse mode’ at times. Although it is not possible to know the answers to these reflexive ponderings, they contribute to robust debate and a deeper consideration of issues before moving on to future research projects which involve the use of interviews.

Researcher as a nurse or nurse as a researcher?

The relationship between the interviewer/researcher who is a nurse/clinician and the older person as interviewee is not a clear one. A nurse’s primary role is to deliver clinical and holistic care and to advocate for her patient. A researcher’s primary role is to answer research questions through exploration of a phenomenon which involves collecting and interpreting data. In colloquial English, acting in a particular way that is commensurate with a particular role, is sometimes referred to as ‘putting on a hat’, a somewhat archaic reference to a time when many people in the UK wore hats, many of which were unique to particular occupations and/or denoted social status (fire fighters helmets, workers flat caps, railway workers’ peaked caps, gentlemen’s top hats). I suggest that the novice nurse-researcher can feel like they are, metaphorically speaking, ‘wearing two hats’, in the sense of carrying out two potentially
conflicting roles and responsibilities at the same time – a nurse’s ‘hat’ and a ‘hat’ for the researcher. This gives them a sense of having a ‘double duty’.

Others have written of ‘role conflict’ and the feeling of having ‘split personalities’ when these two roles come together in the one person. In their paper on this subject, Colbourne and Sque, (2004: 297), write that Sque had ‘no idea how difficult letting go [her] clinical hands-on role and embracing that of a full-time researcher’ would be. She uses reflexivity (guided by Finlay’s (2002) definition of this as ‘thoughtful, conscious self-awareness’) to make sense of the conflict and move on. Colbourne and Sque (2004: 298) acknowledge that it is not only in the actual interview where one has role tension, but also in the analysis of the data: they write that professional socialisation could ‘get in the way’. This observation raises the question: once having become a nurse, can one ever step outside the role? Nurses are socialised into keen observation, assessment and concern for people and this professional hat cannot be taken off easily, even when analysing and interpreting the participants’ own words. Further questions relevant to this research are: Should a nurse ever leave their role behind, even when conducting research? Do nurses’ moral obligations remain when wearing a ‘researcher’s hat’?

Even the nomenclature can be difficult as Deave (2005) points out: Should we be called ‘research nurse’ or ‘nurse researcher’? Role confusion is inevitable as dual roles of being a nurse and a researcher are carried out (Truglio-Londrigan, 2006). In their paper on the challenge of multiple roles in the qualitative clinician researcher-participant relationship, Cartwright and Limandri (1997) noted that the relationship is a multi-dimensional one and that both parties move in and out of different roles throughout the interview encounter. They offer a useful framework which identifies five potential relationships within the interview: 1. stranger-stranger; 2. researcher-participant; 3. friend-friend; 4. nurse-client; 5. guest-host. As mentioned above, it is the relationship between the second and fourth relationships that I am particularly focusing on in the current discussion.

Reflexivity

Gerrish and Lacey (2006: 15) argue that as qualitative research employs an approach ‘where the researcher and the research are closely intertwined’, problems can arise and which render reflexivity a necessary and inherent part of the research.

Finlay and Ballinger (2006: 21) define reflexivity as involving ‘critical self-reflection, focusing on the ways a researcher’s social background, assumptions, positioning and behaviour affect the research process’. The authors go on to emphasise that the ‘purpose of reflexivity is not to achieve neutrality but to achieve a far more intense insight’.

Several authors write on the issue of reflexivity within the process of interviewing where the interview itself becomes the focus of examination. Chesney (2001: 131) writes that she is interested in the use of ‘self’, or as she calls it the ‘me in the research’, and similarly, Watt (2007: 82) hopes to ‘demystify’ the research process through reflexivity. Mruck and Breuer (2003: 1) attempt to ‘achieve new levels of understanding’, and as novice researchers, Colbourne and Sque (2004: 297) use reflexivity to explore role conflict and ‘difficulties in the transition from a clinical post to a nurse researcher role’. All of these support my own intentions in critiquing my role as both nurse and researcher in this paper. The secondary analysis gave me an opportunity to focus on and critique the process or the ‘how to’ of my interviewing technique and exchanges with participants, rather than the content or the ‘what’ of data. Thus I hoped to achieve greater insight into my performance and positioning as a research interviewer.

Method

For the doctoral study, each of the two sets of twenty interviews with the twenty participants were analysed in two ways: firstly using a conventional thematic analysis and secondly using a narrative/discourse analysis. The findings from these two analytical approaches were
synthesised to develop a global account of the data.

The secondary analysis involved identifying and scrutinising those places in the interview transcripts where I was ‘wearing my nurse’s hat’, for example, situations where I was asked to explain what certain drugs were for or what quantity to take or if they were necessary. The analysis identified specific themes derived from these micro-portions of the interviews. These themes are presented and discussed in the section below.

The twenty interviews were read and closely scrutinised for any researcher-interviewee interaction or exchange where I considered that I was acting in a predominantly ‘nurse role’, rather than ‘researcher role’. I was able to code or mark these portions by my change in tone, language and the type of questions I was asking or being asked. Using a model of general thematic analysis (Finlay and Ballinger, 2006), five major themes were identified: advice, assessment, referral, education and reassurance. These themes are discussed with illustrative excerpts below. All names used here are pseudonyms.

Findings

Advice

Advice-giving was one of the main features of the interview portions identified in the analysis. Sometimes this advice was solicited by a participant such as Hazel who invited me to have a look at the wound on her leg. In the middle of discussion about over-the-counter medication, she asked ‘I would like someone else’s opinion, what do you think?’ This advice turned into assessment (the next theme) as well. I was quite cautious as Hazel had spent quite some time criticising her doctor and did not always seem to be trusting of his judgements, so I responded:

LR: Sure yes, have you shown it to the nurse at the doctor’s place?
H: No I haven’t. I’m not going back [for a while]...
LR: Oh, which one are you talking about...this area here?
H: Well, that’s where it all blew up into bubbles, underneath the waterproof dressing that she put on...
LR: It’s not hot. You know, I think it might have been an allergy to that dressing
H: Yes, I thought that’s what it was.
LR: Has it improved?
H: Oh yes, you should have seen it before, it was all leaking
LR: It’s not sore?
H: No
LR: It’s not hot and it’s not sore, it doesn’t feel inflamed...
H: It was redder than that before I put the arnica on
LR: It’s not red and angry and swollen and painful. They are all signs of infection, but still the next time you go to your doctor...
H: Yes, I’ve got to go next month
LR: Yes, I think I would show it to him, or maybe the practice nurse. Is there a practice nurse there?
H: Oh yes, a couple of them and three doctors.

Sometimes the advice was initiated by me. For example on two or three occasions I advised participants to return their unused medication to the pharmacy. In these situations I tried to suggest rather than tell people what to do.

LR: [to George’s caregiver who managed his medications] So in that bag there, that’s the ones he’s no longer taking?
C: Yes, he doesn’t take these anymore
LR: One day it might be an idea to take them back so you haven’t just got them lying around, but that’s just a thought.
Assessment

The illustration of an ‘advice exchange’ with Hazel above was the only circumstance where I was directly asked to assess a situation. I initiated several other assessment conversations, however, secondary to observing symptoms which I considered distressing or unresolved for the participant, as in the case of Alison’s cough:

LR: Have you had anything for your recent chest infection? Did they give you anything for that?
A: No.
LR: Did you go to the doctor?
A: I went to the doctor last week for a re-fill of the tablets.
LR: And did they listen to your chest?
A: No.
LR: You didn't mention it? You weren't worried about it enough?
A: It's come on this last day or two again, the chest like, you know. Always a cough, well not a cough, but.......
LR: You don't feel unwell?
A: No, but I wish I was a bit brighter.
LR: Right. Do you feel a bit sleepy?
A: Yes, dopey, but I'm dopey at the best of times (cough, cough, cough)
LR: Oh, you might have to go back if that doesn't go away.
A: Oh, I've had that on and off for ages. I used to live and work on the Main Road, in Birmingham, and I think all the traffic, you know, in your eyes up to it.
LR: So you've had that cough for a long time?
A: A long, long time, yes.
LR: It comes and goes, does it?
A: That's it.

On listening to the tape and reading the transcript after this interview, I realised I had slipped into nursing assessment mode. I was viewing the participant primarily as patient at this point of her interview.

Referral

The majority of times where I assumed ‘nurse’ role was when I referred the participant back to their GP or practice nurse as I have shown above. This was particularly when I felt I couldn’t answer a question safely or responsibly, in the sense that I didn’t know their medical history or why they were taking particular medications. After the first two interviews I went out and bought an up-to-date nursing Saunders Nursing Drug Handbook (2006) as I felt that if I am going to answer questions, I wanted to be accurate and look drugs up when participants asked me questions about their medications. Referral was also one way of closing a discussion down if I felt the nurse role was becoming too dominant and we needed to return to the research agenda.

Education

Education took the form of giving information (usually about medications, their action or purpose or how and when to take them); ‘checking out’ with participants as to whether they knew the right thing to do; imparting knowledge and answering questions. For example, Rosemary had been in hospital several times for major heart surgery and her medications had been altered constantly and recently reduced:

LR: So do you know what all your medications are for?
R: It's all to do with.....
LR: It's all cardiac.
R: My rhythm is not good in the heart and some of those might be for that. This Digoxin, you don't know what they are either?
LR: Yes, I do. Digoxin slows and strengthens your heart, so that regulates your heart-beat, slows it down.
R: I only take one of those at breakfast time, and I take the Cardizem, one at breakfast.
LR: That's this one.
R: And then I take Enalapril, that's a heart tablet isn't it?
LR: It's an antihypertensive, Enalapril. Yes.
R: Well I take.....
LR: That at breakfast?
R: Yes. It's a funny thing, I thought I took two of those, but no.
LR: It should be down on here.
R: It looks good, just seeing these few now, to what I had.
LR: It must do.

This conversation turned into reassuring Rosemary which leads to the final theme.

Reassurance

On several occasions, I found myself giving reassurance and encouragement wearing my ‘nurse’s hat’. As already mentioned many of the participants were still recovering from surgery in hospital or major medical events and were learning to re-manage their lives in their own homes. Many of them shared narratives of ‘improvement’, although not all. On reflection, I was also giving them a kind of feedback as a representative from ‘the system’ that they were doing well. Sheila was very anxious at not having heard about her cancer pathology results:

LR: And did you have just one breast off?
S: Yes.
LR: Right okay. That was in December?
S: November.
LR: And you followed up with your doctor, just to find out what's.....?
S: That's what I wanted to see, with you know.....
LR: What about your own GP, were they....
S: Oh, he seems to be perfectly organised, there was um...
LR: Perfectly?
S: He's given me the phone number to ring at the hospital.
LR: Oh I see what you mean. He hasn't heard though himself?
S: I haven't heard yet. I wrote, when was it last week, I rang him because I thought it has been long enough now, but she said they are behind, and I know there are waiting lists for everything, and I thought well perhaps I'm hopefully thinking there's nothing else, because she said it was a very tiny cancer that was there.
LR: You would think if it was serious you would have heard by now. It's six months now. If it's urgent they usually get on to it pretty quickly.
S: Yes, pretty quickly.
LR: You could try phoning again... So how are you feeling in yourself?
S: Oh fine, I got over the operation quite well. I can get my arm right up now.
LR: Oh well done.
S: I did all my exercises.
LR: Oh good on you.
DW: And I did that quite well.
LR: That's great.

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Discussion

This paper adopts the viewpoint that the interview is a co-constructed entity, where interviewer and interviewee together create an end product through conversation. The conversation generated is dependent on many factors such as age, gender, context of both parties. Power rests with the interviewer as the initiator, designer of the interview format and seeker of data. Power also rests with the interviewee as the site of the interview is in their domain and they can choose to tell what they want to tell and exhibit the ‘self’ that they choose to present (Goffman, 1981). Shared power however assumes that the two parties are equal and this is often not the case. Older interviewees may be vulnerable due to illness, disability or impaired cognition not just age per se (Wenger, 2003).

In the current research, another kind of power difference manifested itself in the form of the interviewer wearing two professional hats: that of nurse and that of researcher. The literature offers no ‘right’ way to manage this tension along a ‘subjectivity-objectivity continuum’, although various authors have explained their approach and rationale (Colbourne and Sque, 2004; Chesney, 2001).

I made it clear to all interviewees from the outset that I was a nurse, in addition to wearing my badge (‘Lecturer, Centre for Postgraduate Nursing Studies’). I felt that it was important to deliberately identify myself and where I came from as the participants had never met me before apart from a brief phone call arranging the time and venue for the interview. One reason I was deliberate in my declaration that I was a nurse was that I felt this gave me some status and authority to be in strangers’ homes. So I initiated and set the scene for a ‘mixed’ (nurse and researcher) relationship. I was seeking legitimacy and this was how I positioned myself (Davies and Harré, 1999). I also felt comfortable and ‘at ease’ in a familiar role and undoubtedly generated this comfort, which I believe is a requisite for establishing rapport and a successful interview.

In stark contrast to my approach, Colbourne used devices (Colbourne and Sque, 2004) to make explicit her primarily researcher role, via both written information and verbal reinforcement. She did this in order to avoid bias and to remain true to the participant’s story. Even though I too had ‘researcher authority’ via ethical approval, (a clear information sheet and a signed consent form) which gave me legitimate and formal access, I felt that as I was to be asking participants about health-related matters (medications), I might put them more at ease if they knew that I had some professional knowledge and insight into the topic. As researchers, we are ethically obliged to encourage respect and trust in interview relationships. My experience of trust is that it is not assumed, but earned. Both consciously and unconsciously, I was offering myself as a nurse (with all that the role implies: advice, assessment, knowledge, education, reassurance) as a way of saying ‘Trust me’; ‘I am trustworthy’ (not that all nurses or health professionals necessarily are).

I was also concerned about reciprocity. I felt that, although consenting to be interviewed, participants were doing me a favour. They were not at all obliged to have me come and ask them lots of questions When I thanked participants at the end, many said ‘Oh well, as long as it has been of help’, when a more pressing concern for them (as recently incapacitated) surely must have been obtaining home help which my District Health Board colleague had assessed them for the week before.

The information sheet was 3 pages long (necessarily to meet all the requirements of the Ethics Committee), and although written in lay language, it was still the language of research. In other words, the core purpose of the interview and research in general was mine, not theirs. I was in the domain of their house but they were in the domain of my research. By making it clear that I was a nurse, I felt I was giving them reason to trust me, to know I was genuine and that through advice, concern and information, I could give them something back.

I believed the interviews were strengthened by the approach I took at the time. I am not sure that I would emphasise my nurse’s role to the same extent in the future as I think this
reflection has led me to conclude that this was due to my own role transition and developing confidence as a researcher. I set my terms and conditions out clearly from the beginning by saying I was a nurse and a researcher who had come to ask them about their medication. In a sense, both roles were carried out in tandem. The compatibility of the two roles rests within my ‘presented self’ (Goffman, 1981) as an individual interviewer and it would be perhaps impossible to untangle them. The wider question of compatibility between the dominant discourse of nursing (to help, advise, refer, give information, form relationships) and the dominant discourse of research (to seek information, contribute to useful knowledge, to form relationships) depends on where one stands on the subjectivity-objectivity continuum. Both discourses have much in common if the researcher initiates an involved, subjective, partnership stance and a climate of trust and reciprocity is fostered. This is the stance I tried to take in the case of the current research. It did not extend to friendship and ongoing relationship, nor did it ‘stick to its core objective business’ at all times. It is probably half way along the continuum. I believe that an ease in weaving in and out of both roles was achieved. Participants had their questions and concerns answered by information and referral and as researcher I was able to collect much rich data for my doctoral thesis. It would have most likely been helpful to have a set of strategies in place to manage clinical questions, such as stating that I could answer any questions about treatment, medication and so on at the end of the interview. I could have deflected, delayed and denied offering immediate help or answers and focused on the job of interviewing. This approach might have been legitimate as a researcher but it did not occur to me to have strategies other than to switch intuitively to an ingrained nursing role.

Prior consideration and discussion and reading about the mechanics of interviewing skills can be useful, but in my case the dual tension I experienced was unexpected. Reflection on the interview process as a final but necessary step in the analysis of data has been a useful tool in retrospectively exploring the metaphorical phenomenon of ‘wearing two hats’. Perhaps the truth of the matter is that several hats (at least two) are being worn at once throughout the interview. The important thing is to acknowledge one’s behaviour as a researcher by reflecting on each interview/research project and thus gaining greater self-awareness and clarity for future projects.

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**Lorraine Ritchie** is a Lecturer in the Centre for Postgraduate Nursing Studies at the University of Otago, Christchurch, New Zealand

lorraine.ritchie@otago.ac.nz