Qualitative research interviewing by general practitioners. A personal view of the opportunities and pitfalls

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**Objective.** This study looked at the role of the GP as a qualitative research interviewer and aimed to illustrate areas of methodological difficulty using personal observations made during a qualitative study in general practice.

**Methods and results.** The recently published literature on qualitative research in general practice was reviewed by the author to inform her own qualitative study looking at how women decide how to feed their babies. Some women in the study were patients of the author; some knew that she is a GP but were registered at another practice and some did not know that she is a doctor. In-depth and semi-structured interviews were tape recorded and transcribed. Observations about combining general practice and qualitative research were recorded by the author in a research diary.

**Conclusion.** Qualitative research is being advocated as a methodology appropriate for general practice, yet there are many unanswered questions about methodological detail. There are no guidelines to help GPs to decide whether it is appropriate for them to do the interviewing, the practicalities of doing it, and whether they should use their own patients. There is clearly a need for more methodological research to look at how these decisions influence the data and to inform GPs who are considering a qualitative study.

**Keywords.** General practice, interviewing, methodology, qualitative research.

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**Introduction**

Many authors have suggested the need for qualitative research in general practice to complement quantitative methods.1-4 The skills required for qualitative interviewing have been extensively documented,5-9 however two areas have not been addressed in detail by the literature. First, who is the most appropriate person to collect qualitative data in general practice—is it possible for a GP to wear two hats? There is little published research comparing the quality of data obtained by interviewers with medical and social science backgrounds. Does it differ and how important is this? This debate will need to involve wider issues than pure research methodology. The economic and recruitment climate in general practice needs to be considered as qualitative research is more costly in terms of researcher time. Second, should GPs interview their own patients?

The ethical concerns about patients feeling obliged to consent to the research have been discussed.10 Distressing events may arise in the interview, and there is an issue about how these are followed up. This may be easier to negotiate for a GP interviewing practice patients than an independent researcher. It has also been pointed out that there can be a tendency to take the path of least resistance and study the most easily accessible subjects, who may not be the most appropriate for the research question.9,11 On the other hand collaborative research between participants and researchers has been proposed as a way to close the research–practice gap and improve the implementation of research findings.4 An example of such collaborative research involving GPs and their patients is a paper by Hamberg and colleagues, who studied female patients suffering from chronic pain in the locomotor system.12 Here research was undertaken at the same time that a practical problem was being solved, a situation which the authors argue is ideally suited to general practice. Creating a sense of collective ownership or stake-holding in primary care research has also been suggested as a strategy for improving recruitment and enhancing the quality of data.13

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Received 4 December 1996; Accepted 3 April 1997.

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The aim of this study was to look at the role of a GP as a qualitative interviewer and illustrate some of the methodological issues raised in the literature with examples from my own experience.

Methods

I am working both as a principal in general practice and a qualitative researcher, with supervision from an experienced social scientist in a department of general practice (RP). I am also involved in teaching communication skills to undergraduates and GP registrars.

To inform my research methodology, I systematically reviewed published papers on qualitative research in general practice to look at how they dealt with the issues of who should be the interviewer and whether GPs should interview their own patients. These issues were rarely discussed, and often the reader was left to make assumptions about the relationship between the interviewer and the interviewee. I found several discussion papers on qualitative research in general practice but no guidelines for GPs on how to put the theory into practice.

My study involved semi-structured and in-depth interviews of primigravida pregnant women, in their homes, about their infant feeding intentions and the decision-making process. The initial pilot interviews were undertaken on women registered with my practice who knew me as a GP. For the main study, I decided to interview women recruited by midwives and GPs from practices where I was not known as a GP, to reduce the risk of women giving the answer that a health professional might expect. In fact a few women discovered that I was a GP through accidental slips made by the recruiting professionals. I had difficulty recruiting women who wanted to bottle feed, so towards the end of the study I recruited a few more women from my practice. Focus groups were also used to collect data. The interviews were tape recorded and transcribed.

This paper has emerged from my own reflections, observations and experiences recorded in a research diary and from the interview transcripts. I will take methodological issues facing a GP doing qualitative research and illustrate these with examples from my research. The different roles which I have experienced are (A) as a GP in a consultation that is patient-centred and more behaviour- than task-orientated; for example, meeting for the first time a woman expecting her first baby who presents with ‘depression’; (B) as a GP/researcher interviewing a woman who does not know that I am a doctor: she is told that I am a researcher; the aim of the research is to look at the infant feeding decision-making process but the woman is told that it is about choices women make when they are having a baby; the woman is unknown to me and has been recruited by another practice; in-depth and semi-structured interviewing techniques are used; (C) as a GP/researcher in the above role, but interviewing a woman from my own practice; and (D) as a GP/researcher interviewing a woman from a different practice, who is told that I am a GP. There is another possible role, with the GP as a researcher on a non-medical topic about which he/she has no expert knowledge. I have no experience in this role and will not refer to it.

Comparing the aims and objectives

One of the strengths of qualitative research is the cyclical nature of data collection, analysis, modification of the research question and subsequent data collection. It is not dissimilar from the holistic model of family medicine described by McWhinney, despite the different agendas. Britten and colleagues emphasize the fundamental difference in orientation between the consultation and the qualitative interview. They argue that however patient-centred a consultation is, ultimately the patient’s perspective is redefined in terms of the doctor’s model, to enable management decisions to be made. In contrast, qualitative researchers aim to understand the subject’s own framework and meanings rather than imposing their own. All roles share the common aims of facilitating discussion and doing no harm. The consultation is for the benefit of the woman, who has presented herself and who will have hopes and expectations about the desired outcome. The research interview is for the benefit of the researcher and the advancement of knowledge and understanding. Each woman is likely to have a different understanding of this which may influence recruitment to the study and the data obtained. How the study is presented to the woman is of paramount importance.

By interviewing patients in role C or D the possible bias of women giving the answer which they think the GP expects can occur. On the other hand, access to hard-to-reach women may be improved. There are certainly ethical concerns that patients may feel obliged to participate in view of the continuing doctor–patient relationship. When interviewing anonymously (role B) a different set of biases are likely to be operating, which may be harder to define, but involve issues such as confidence with strangers, control over environment and motivation.

Example. As a GP interviewing my own patients (role C) I had no difficulty recruiting women with differing views about breast feeding. As an unknown researcher (role B) I asked local GPs and midwives to recruit suitable women. Despite low breast feeding rates in the population I was targeting, I had great difficulty recruiting, particularly women who wanted to bottle feed. This was contrary to expectations.
Interview 19 (role C). I interviewed one of my patients who was ambivalent about breast feeding. After the interview, I asked her how she would have felt if I had been an unknown researcher. She replied that she would not have consented to the research, as she felt too shy and embarrassed talking to strangers about her pregnancy.

Comparing the context—access, setting, timing and preparation

The consultation is usually patient-initiated and problem-orientated, whereas the research interview is researcher-initiated. For both the interviewer and the interviewee recruitment, negotiation of time, place and people present at the interview, are more complex and less familiar processes than making an appointment to see a GP. This has implications for women in terms of the control they have about the issues discussed, the value of the time taken and the priority they attribute to it. Subjects are more likely to engage in a conversation if the issue is a priority for them and if they think that the interviewer can accept and understand their viewpoint.

Example: interview 3 (role B). On arriving at the pre-arranged time, the woman told me she had an appointment with the council about her housing situation in 1 hour. The interview did not run smoothly. It was difficult to facilitate conversation and build a rapport. She was constantly watching the clock as housing was her priority. As a result I felt the data were less spontaneous and rich than in other interviews and in retrospect, I should have re-arranged the interview.

Example: interview 18 (role C). I offered to interview the woman at home, but she wanted to come to the surgery and stated that doctors are far too busy to do home visits. I had planned to do the research interviews in the woman’s home to avoid the influence and the interruptions of the medical setting. As a GP I encourage patients to come to the surgery where possible rather than request home visits. I was embarrassed to realize that I was giving the message that home visits are fine for research but not if you are ill.

The GP consultation usually has a time constraint unlike the research interview. There are differences in pace, stress levels and behaviour patterns. A GP can have baggage left over from a previous consultation that influences the current one. Ideally a researcher plans interviews to allow time and space before and after for reflection.

Example: interview 4 (role C). The interview was arranged for a late afternoon. Prior to the interview I was at the surgery doing paperwork. I had planned a quiet half hour beforehand to focus on the aims and objectives of the interview. As I walked through the reception area a receptionist said she had a telephone call for me. It was a social worker informing me that a 17-year-old patient of mine was suicidal and threatening to throw herself off a bridge. By the time I had handed this problem over to the duty doctor it was time to go to the interview. The resulting interview contained more direct questions than I would have liked, several missed cues and I was less relaxed than usual. Interviews were more successful on days when I was not based at the practice.

For many people going to the GP has become part of normal life and a common experience. People have expectations about what will happen in the consultation and how it will happen. The majority of people will not have talked to a researcher and may have differing expectations about what occurs in an interview. It is a new and somewhat unnatural situation that may generate unexpected fears and anxieties for both the interviewer and the interviewee. The quality of the data can be influenced by how the research is presented. Time is spent talking about the ground rules and boundaries, e.g. informed consent, confidentiality, freedom to stop the interview at any point, who will be present, timing, and what to expect.

Example: interview 12 (role B). I thought it was going to be a questionnaire.

Example: interview 15 (role B). A 16-year-old girl still at school, paused and looked anxiously at the information and consent sheet prior to answering my questions. She seemed to see me as a teacher who expected the correct answers.

Rapport and communication skills

Patients often have a pre-existing trust in the GP they are seeing. As a researcher considerable effort is often required to establish and constantly re-establish trust through the interview. GPs are unfamiliar with having to do this as trust is often assumed. Elder and Miller point out that there needs to be sufficient contact between the researcher and participant to develop trust and understanding, but if they become too close, objectivity and perspective may be lost.9

Example: interview 10 (role B). I found it very difficult to establish a rapport, she answered questions very briefly and I felt quite uncomfortable. Her husband was in the kitchen. I suggested he could join in if she wished. Conversation then started to flow much more freely and the atmosphere became less tense.

I had no difficulties establishing rapport with women in roles C and D, and rarely had problems as a GP in role A. Interviews where the woman chose to have
someone with her resulted in more spontaneous and better quality data. Whittaker similarly found joint interviews with spouses the most informative.  

Judith Scott states that qualitative researchers should aim to minimize the social differences such as status, educational level, expertise and appearance. A chatty conversational style is constantly juggled with the data collection agenda, which needs to be clear and precise to ensure quality. In the consultation the social differences are overt, although attempts may be made to minimize doctor–patient boundaries. To be both a GP and a qualitative research interviewer requires an ability to change style characteristics convincingly. To what extent can this be learnt?

Example: focus group 1—four women in their late teens (role B).

Woman: “Are you a doctor?”

Interviewer: “I am a researcher.”

Woman (to the others in the group): “She looks like a doctor, doesn’t she?”

I was attempting to minimize my differences from the group and not look like a doctor. I feel that it is unrealistic to believe that this can always be achieved. How easy is it to hide a medical hallmark? This quotation also raises the issue of honesty, which I will return to later.

In roles B, C and D, the researcher’s agenda remains hidden throughout the interview to allow the women to use their own framework. GPs are familiar with a patient having a hidden agenda and it is widely acknowledged that these consultations can be difficult. They are less accustomed to holding the hidden agenda themselves. Rapport can be more difficult to establish than in a consultation where the GPs agenda is usually clearly stated with opening questions like: ‘How can I help you?’ In my study, I told women that the interview was about choices they would make when they have a baby as I wanted to see in what context women raised the issue of infant feeding.

Example: role B.

Interviewer: “Once you have had the baby, what is going to be important for your baby’s health?”

Woman (Interview 8): “I don’t know what you mean ... I don’t understand.”

Woman (Interview 13): “I’m not sure I’ve got you on that one.”

Similar incidents occurred in three other interviews and created some unease until conversation started to flow again. To counteract this, I often declared my agenda once feeding had been raised spontaneously by the woman and my impression is that this facilitated the interview.

Britten et al. note the similarities in communication skills required for qualitative interviewing and GP consultations: using open-ended questions, paying attention to verbal and non-verbal cues and allowing the patient’s perspective to be presented. The validity of the data collected in the research interview can be affected by whether it is offered spontaneously by the woman. Information obtained about issues introduced by the interviewer is likely to reflect the interviewer’s priorities and framework rather than the woman’s. In contrast information obtained by direct questioning in a GP consultation may be of equal validity and value.

Example: role A. A direct question might reveal that the woman has lost weight. The woman herself might not consider this to be important in relation to her depression. To the GP it might raise the possibility of a systemic illness or alert him/her to the severity of her illness.

In the consultation the GP often curtails tangents which the patient may pursue and returns to the main agenda. This is often due to time constraints in general practice. In research interviews tangents are often not curtailed, as they reveal issues of central importance to the woman and provide important contextual information for analysis.

Example: interviews 1, 3, 5, 13, 20 (roles B and C). Dissatisfaction with housing was a priority for these women. The subject was talked about at length. The data reveal some of the stresses and strains this places on everyday life and is one of the complex interplay of factors which influence a woman’s decision on how to feed her baby.

GPs have skills in establishing the health beliefs of patients by following up cues, probing and clarifying topics raised. These skills require fine tuning for qualitative interviewing to detect the subtle nuances and ambiguities of language. Strauss and Corbin illustrated how prepositions like ‘once’ may have many different meanings. In each sentence there are often several cues which could be followed, and these increase exponentially as the interview proceeds. Which cues are explored and which are left unexplored can influence the quality of the data.

Example: role B.

Woman (Interview 9): “I feel breast feeding would be better ... it seems clinical to bottle feed.”

Woman (Interview 1): “They say breast feeding is best. . . .”

These two simple statements provide several cues. Interview 9 suggests ownership and commitment to the statement by using the first person singular, whereas Interview 1 suggests less commitment and a distancing from the statement by using the third person plural. The words ‘best’ and ‘better’ may not necessarily refer
to the same object or context. In interview 9 the verb ‘feel’ is used in preference to ‘know’ or ‘think’ and probing may give insight into how this particular woman has made her decision to breast feed. In fact I followed up the word ‘clinical’.

**Ethical considerations**

In a consultation, a GP does not usually collude with beliefs expressed by the patient which are contrary to established medical knowledge. As a researcher, I found this grey area between honesty and collusion an area of conflict.

**Example: role A.** If a woman admits to drinking 5 units of alcohol a day, a GP would discuss the health implications of this for her and her baby. In a research interview (roles B, C, D), it could be perceived as colluding if the interviewer fails to comment on the health implications. However, by raising the health implications the subsequent data might be influenced.

**Example: focus group 2 (role B).** Women were talking about bottle feeding resulting in fatter, healthier looking babies. Having a plump baby was thought to be a sign of well-being.

M: “There’s a girl over there, since her baby was 3 weeks old, she’s fed her baby bottled cow’s milk. He’s like a body builder.”

N: “He’s that big he can’t hold his weight!”

M: “It suits him, he looks lovely with it.”

K (to Researcher): “Is it dangerous?”

Researcher: (pause) “Yes it is. They say you shouldn’t give bottled milk before 6 months.”

I paused to think how I would respond, but felt that ethically I should answer the question. I consciously attempted to distance myself from the advice by using the words ‘They say . . . ’. Alternative responses could be to answer questions at the end, to ask others in the group how they feel or to deny knowledge.

Initially, I found it difficult to refuse to answer questions, particularly when the woman knew I was a GP (roles C and D). With experience I found it best to raise the issue prior to the interview and agree to answer questions at the end, as I feel that it is unethical to withhold knowledge in situations where there could be adverse health outcomes. By deferring questions until the end of the interview, the validity of the data is less likely to be affected; however, it could alter the woman’s perceptions and subsequent responses in follow-up interviews.

**Conclusion**

Qualitative research is being widely advocated as a research methodology appropriate for primary care and increasingly GPs are becoming involved. As a GP involved in teaching consultation skills, I had appreciated the theoretical difference in orientation required for qualitative interviewing, but did not anticipate some of the more practical difficulties. I have not found it as easy as I expected to fit between these two roles, particularly letting go of my medical framework.

My interviewing skills were better with women who knew that I was a doctor and conversation seemed to flow more freely. In future, I would tell respondents that I was a doctor doing research, and would suggest that any questions could be answered at the end of the interview. Whether a GP should interview their own patients will depend on the research question and how closely associated it is with aspects of medical care. It could improve access and recruitment for hard to reach sectors of the community, as demonstrated in my study. This has to be balanced against the possible bias of patients giving the expected answer. Raising this as an issue for discussion with the subject prior to the interview may be a way reducing this bias.

Although I gained valuable information about the priority women gave to the infant feeding decision, by being vague about the main purpose of the interview, in retrospect I would have preferred to have been more open. My impression is that rapport and trust is more difficult to establish and the quality of the data can suffer. This paper has raised issues which may not be generalizable to other GPs undertaking qualitative research. However, it has highlighted the need for more methodological work on how decisions about who does the interviewing and their relationship to the respondents can affect the data and the need for guidelines on doing qualitative research in general practice. Research in primary care can be strengthened by a multi-skilled and multi-disciplinary approach where GPs have hands on experience of qualitative research. However, we are still at the starting post in identifying how GPs can most effectively contribute to this relatively new field.

**Acknowledgement**

Dr Pat Hoddinott has a Royal College of General Practitioners Research Training Fellowship which has helped fund her research.

**References**

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