

Methodological and Ethical Considerations when Conducting Qualitative Interview Research With Healthcare Professionals: Reflections and Recommendations as a Result of a Pandemic

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Abstract

The impacts of healthcare professionals (HCPs) being research participants are often neglected. As professionals, they tend to be perceived as 'immune' to many negative effects of sharing their experiences. However, in the context of an ongoing global pandemic such as COVID-19, these assumptions can be clearly challenged. This article draws on researchers' experiences of conducting single and longitudinal qualitative interviews with HCPs during the COVID-19 pandemic in Europe during 2020. Reflecting on the methodological and ethical implications of doing such research during a pandemic allows researchers to surface assumptions about and question categories of 'vulnerability' and 'sensitivity'. We explore these categories in relation to three issues we have identified: (i) Blurred boundaries in researcher-participant relationships; (ii) Interviews as spaces to process experiences; and (iii) Motivations to conduct and participate in research. We demonstrate that qualitative interviews during a pandemic are embedded in sense-making processes for both the interviewer and participant, and as such may play an important role in coping and resilience. We therefore argue for ethically active research that critically engages with the concepts of 'vulnerability' and 'sensitivity', and underpinning assumptions, in context over time throughout the research process for current and future research with HCPs and other groups beyond pandemic situations. We thus aim to prepare researchers for managing these potential facets during the research process. We conclude with practical implications for managing emerging ethical tensions, methodological challenges and the wide-ranging possibilities and responsibilities for research with HCPs, urging researchers to consider the issues in advance.

Keywords

vulnerability, sensitive topics, qualitative research, research participants, ethics

Introduction

While there is a general consensus that conducting qualitative research in healthcare needs to be ethical, qualitative research with healthcare professionals (i.e. clinically-trained health workers, henceforth HCPs) is often perceived as posing few, if any, ethical challenges (Hoddinott & Pill, 1997; Hysong, 2013; Molyneux et al., 2016), especially in comparison to research with patients. Consequently, researchers in these areas may rarely discuss issues related to, for example, tensions in building a rapport, dealing with distress or need for

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debrief, and how to manage these in practice throughout the research process.

In the context of their clinical responsibilities, HCPs may be perceived as individuals with the skills and training to be resilient and cope with stressful situations in the course of their work. This perception may then be transferred into the research context, where they become seen as ‘invincible’ participants. For example, research on HCPs’ views may not be seen as particularly problematic. This may contribute to researchers understanding HCPs as not needing much explanation about research processes, or time to debrief with researchers. By contrast, certain patient groups may often be perceived as being particularly vulnerable in the context of qualitative research, especially in terms of certain topics that are deemed ‘sensitive’, which can often contribute to gatekeepers being overprotective (Alexander, 2018; Witham, et al., 2013).

During the COVID-19 pandemic, however, a wealth of literature has been produced concerning health worker wellbeing, mental health and burnout linked to the emergent nature of the crisis, unmanageable workloads, resource shortages and patient deaths (Alhrabi, et al., 2020; An, et al., 2020; Greenberg, 2020; Luo, et al., 2020; van Hout, et al., 2022). Whilst these issues are by no means unique to the COVID-19 pandemic context, this situation has thrown them into stark relief. The pandemic has thus highlighted and magnified some of the ethical and practical tensions that emerge when conducting research with HCPs; and the insights and implications from this period can be far-reaching, beyond the pandemic context. As key concepts guiding researchers’ approaches and responses to such tensions, ‘vulnerability’ and ‘sensitivity’ are therefore particularly pertinent to consider here. We introduce these concepts first, and then discuss what they may mean when conducting interviews with this particular group.

What and Who is Vulnerable?

The definition of vulnerability for research participants varies. We understand the state of being vulnerable as being exposed and/or susceptible to the possibility of harm (e.g. physical, emotional and psychological) (Aldridge, 2014). Generally, this could take the form of exploitation, deprivation, exclusion, offence, injury, etc., and by extension implicates sociocultural and politico-economic relations which may contribute to states of vulnerability. As a multifaceted concept, related to the complexity of challenges experienced by individuals, during the research process vulnerability could include real or perceived threats to individuals’ autonomy, or inequalities existing between them and the researcher (Peternelj-Taylor, 2005).

Literature relates vulnerability to: (i) participants’ characteristics, such as age (e.g. older people or children being often perceived at high risk of exploitation and requiring more safeguarding processes (Farrell 2005)); (ii) participants’ difficult experiences or situations, such as life-threatening illness (e.g. cancer patients or people who experienced bereavement) (e.g. Cook, 1995); or (iii) certain groups which are perceived

as either having multiple risk factors (Gifford, 2013), being ‘hidden’, or marginalised (e.g. drug users or immigrants).

What Counts as Sensitive and for Whom?

Lee and Lee (2012) categorises what may constitute a ‘sensitive topic’ as (i) ‘private, stressful, or sacred’; (ii) stigmatising, such as illegal or socially unacceptable behaviour; and (iii) related to political threat, controversy and/or social conflict. We take sensitivity in research to therefore refer to potential costs to those involved in that research (including the researcher) – potential intrusiveness, adverse reactions (e.g. emotional, legal and wellbeing) and risk in how the information gathered is used, presented and/or accessed by third parties, linked to social and other implications (Tourangeau, 2008). The sensitive character of research is thus highly context-dependent, and overall may constitute a ‘threat to those who are or have been involved’ in it. (Lee, 1993, p. 4).

Reconsidering the Concepts of Vulnerability and Sensitivity in Research with HCPs

The aforementioned definitions of vulnerability are most often applied to patients in health research and are rarely considered in relation to HCPs. However, in the pandemic context, HCPs may fall into the second category of vulnerability, relating to dealing with difficult situations. During the COVID-19 pandemic, HCPs have managed unprecedented levels of uncertainty and pressure. Wholesale overhauls to delivery of care, lack of resources and personal risk of contracting COVID-19, have already been shown to have detrimental effects on HCPs’ mental health (An, et al., 2020; Jia et al., 2021; Luo, et al., 2020; van Hout, et al., 2022; Wanat, et al., 2021b; Sperling, 2021). It seems the vulnerability of HCPs has become a focus for health policy, highlighting numerous stressors in their work exacerbated by and/or resulting from the COVID-19 pandemic.

HCPs’ experiences and work would also rarely be considered as falling into any of the sensitive topic categories. For example, topics such as dealing with death or difficulties at work are often considered sensitive in research with patients, but far less so when discussed by HCPs in the context of their professional roles (Alexander 2018; Gysels 2012). However, in the context of the pandemic, professional and personal spheres became far more blurred, for example, with changes to professional lives also impacting day-to-day lives, and vice versa. While these may not be the main focus of our research projects, the wider pandemic context unavoidably informed and made it difficult to exclude these aspects from the experience of interviews, for both researcher and participant.

Disrupting Categories

It is important to highlight that whilst sensitive topics and unanticipated disclosures might emerge in any study, sensitivity

and vulnerability often overlap in literature. More importantly, these are most often considered in some research contexts, with some participants, whilst not others; for example, often the elderly, children or refugees, particularly in precarious or marginal positions (Taket, 2008). These and cognate categories are used in literature to discuss specific ethical tensions, challenges and risks in qualitative research methods and practice, for both participants and researchers (Dickson-Swift, et al., 2007; Liangputtong 2007).

However, literature also highlights that these considerations and concerns do not always match up between different groups involved in the research process (Gysels, 2012). Indeed, governance and ethical bodies make judgements and assumptions about vulnerability and sensitivity that do not necessarily reflect the experiences of researchers routinely conducting research in healthcare (Buckle, 2010); and there may similarly be incongruity between the perspectives of research ethics boards and research participants in relation to what is considered a distressing or sensitive topic, or not (Lee & Lee, 2012). There is also a significant portion discussing how researchers themselves can be impacted by research on sensitive topics (e.g. Behar, 1996; Bahn & Weatherill, 2013; Gleeson, 2021; R. Smith, 2021; Fenge et al., 2019), although this is not the primary focus of this article.

Batchelor and Briggs (1994), amongst others (e.g. Orb, et al., 2001) have highlighted the importance of researchers explicitly addressing ethical issues in order to prepare for the unpredictable nature of qualitative research. Whilst ethics applications prompt consideration, understandings in clinical and/or healthcare research may be underpinned and limited by the binary presentation, in these applications, of vulnerability and sensitivity as tick-boxes. These concepts are of crucial importance to understanding the risks and consequences of research, and therefore undertaking safe, ethical, effective research (Lee, 1993). Reflexivity contributes to safe and ethical research practice through building awareness of practical and ethical dilemmas that may arise in the research process, and being ready to respond to them if they do (Guillemin & Gilliam, 2004). Different expressions and contexts of vulnerability and sensitivity may emerge over the course of research, and require different tools that respond to the needs of and potential risks to researchers and participants in context (Alty & Rodham, 1998; Brewer, 1993).

This means continually attending to and examining how the researchers are understanding and identifying ‘vulnerability’ and ‘sensitive’ aspects as research dynamically unfolds, and researchers learn more about the context and participants, while also adapting to the context of that particular time, that is, a bottom-up rather than top-down approach. Critically interrogating understandings of these concepts, what is at stake and how they apply to the research at hand is an essential part of reflexivity that should inform data collection and interpretation (Lee, 1993). We aim to extend these

considerations by disrupting the categories of ‘vulnerability’ and ‘sensitivity’ as they are routinely applied (or not) to HCPs.

We argue here that the context of a pandemic challenges traditional thinking about HCPs as invulnerable participants, in qualitative research with this group more generally (i.e. beyond pandemic situations). It is therefore worth re-considering these categories to discern implications for current and future research. The pandemic context allows us to critically examine the notions of vulnerability and sensitive topics in a new light, and to reflect on how researchers can mobilise these considerations in productive ways when conducting research with HCPs. While this examination is triggered by the specific context of the pandemic, as described earlier, we argue that the process of critically engaging with these issues should not be limited to this context. Rather, we argue that the pandemic allowed us to examine these previously neglected issues with regards to HCPs in a new light. This allows us to highlight that seeing all participants as vulnerable all of the time may not be accurate or useful; and that these categories are dynamic and interacting over time, even over the course of a research relationship or a single interview.

Learning From Research With HCPs During a Health Emergency

Rather than painting whole categories of participants with the same brush, more in-depth engagement on an ongoing individual basis may be beneficial for researchers and participants to facilitate high-quality and ethical research. Researchers must therefore be prepared to consider these issues with HCP participants appropriately, in context, throughout the research process. Indeed, considerations of vulnerability and sensitivity are relevant from ethics applications and ending research relationships, to analysis and presentation of findings; and become enmeshed with the particularities of the project undertaken (Liangputtong, 2011).

We therefore draw on our own experiences conducting research during this time, and focus on how these considerations might emerge, and be managed by researchers, throughout the research process. We argue that the a priori application or dismissal of these categories, ‘vulnerable’ and ‘sensitive’, early in the research process retards the necessary ongoing and critical interrogation of the applicability of these categories in context throughout research; and therefore, also prevents the researcher from more fully preparing themselves to manage these potentially shifting tensions, in the field and out of it.

Reflecting on our own research experiences, we seek to explore answers to the following questions. In interviews with HCPs during a health emergency, what kinds of emerging ethical and methodological tensions face qualitative researchers when considering what and who is vulnerable, and what counts as sensitive and to whom? How might these be managed in context? We therefore focus on three key issues:

- a. Blurred boundaries in researcher-participant relationships
- b. Interviews as spaces to process experiences
- c. Motivations to conduct and participate in research

We reflect on our experiences of conducting interviews with primary, secondary, tertiary and allied HCPs in a number of European countries during the COVID-19 pandemic. Author 1 (MW) conducted and/or analysed interviews with 80 HCPs working in primary care between April 2020 and July 2020 from eight European countries, which included England, Belgium, the Netherlands, Ireland, Sweden, Germany, Greece and Poland (Wanat et al., 2021, 2021b). These interviews were conducted over the telephone and lasted between 17 and 86 minutes (modal average 43 minutes). The aims of the study were to understand HCPs views and experiences of delivering care for patients with respiratory tract infections during the COVID-19 pandemic. Author 2 (CP) conducted and analysed over one hundred interviews with 14 HCPs in primary, secondary and tertiary care in the UK from February 2020 to February 2021 (Atkinson et al., 2020; Pilbeam et al., 2021); interviews lasted between 20 and 80 minutes (modal average 45 minutes), and all interviews were conducted remotely via telephone or teleconferencing. The aim of this study, as presented to participants, was to understand the impact of COVID-19 policy changes for HCPs. Author 3 (SV) conducted and/or analysed over one hundred interviews with COVID-19 trial participants, a proportion of whom were HCPs between August 2020 and September 2020; and conducted qualitative analysis of HCPs' posts on social media, between January 2020 and February 2021 in the UK (Hoernke et al., 2021; Mitchinson et al., 2021; Vindrola-Padros et al., 2020a; Vindrola et al., 2020b). Interviews were conducted online and lasted between 45 and 90 minutes (modal average 50 minutes). The aim of the study was to understand experiences and views about the COVID-19 pandemic and attitudes to vaccine trials and vaccination. Across the three studies, we conducted over three hundred interviews, comprising over 160 hours. Throughout the data collection and analysis (between April 2020 and June 2020), authors met on a regular basis to discuss each other's datasets and share reflections. These meetings provided the groundwork for this manuscript, as we found that our experiences resonated with each other, and this process allowed us to identify key points of comparison and learning. We identified vulnerability and sensitivity as dynamic concepts weaving throughout our experiences, and we interrogated our understandings through discussion and repeated rounds of writing, editing and reviewing as part of the reflective and sense-making process. The reflection we present here is necessarily somewhat consensus-based and linear, but we nevertheless see reflexivity as an ongoing and shifting process. Whilst we have interwoven experiences from distinct research projects to highlight shared learning, we have also preserved unique insights from each of these.

In what follows, we examine what interviewing HCPs during a pandemic may involve for participants and researchers, focussing on what being a 'professional' as a research participant during a pandemic means. Using shared insights from these disparate projects, we also make recommendations regarding the practical implications of the methodological and ethical challenges which this reflection presents.

Blurred Boundaries in Participant-Researcher Relationships

Establishing and maintaining rapport with a participant is a complex task, but is often simply described as building a successful relationship with a participant to facilitate the gathering of high-quality data (Prior, 2018). While this seems straightforward, how it is achieved is more difficult to capture: some see it as showing empathy without judgement (Patton, 2014); some as openness (Gubrium, et al., 2012) or just active listening (Gubrium, et al., 2012; McClelland 2017); whilst others frame it as forging a connection through shared experiences (Morse & Field 1995). Further, rapport-building (and therefore the shaping of the interview itself) begins even before a formal interview starts, for example, at recruitment and potentially through different mediums, such as phone calls, emails, or face-to-face encounters (Miller, 2017).

Rapport is important not only in establishing research relationships and engaging with participants, but is also crucial when disengaging and ending these relationships. However, there is often little consideration of strategies for disengagement, and the terms related to this process are varied. Morrison et al. (2012) highlight that the quality and duration of the relationship and/or interview is important in negotiating endings (Morrison, et al., 2012). While in many cases this negotiation might simply involve thanking participants and allowing them time for concluding remarks or questions, for some it may require something more. This might be especially the case if participants revealed, or felt that they revealed, more than they expected, and may need to process what happened during the interview; this might also be magnified in longitudinal research (Warin, 2011).

In the establishment, maintenance and ending of participant-researcher relationships, researchers have highlighted how engaging and immersing themselves in the worlds of participants 'blurs boundaries' (e.g. in ethnography see Koff (2005); in interviews see Dickson-Swift et al. (2006, 2009)). For example, given the immersive nature of the COVID-19 pandemic for both researchers and participants, who share a context as living in, with and through the pandemic, boundaries between personal, professional, private and participant may become blurred for both. The pandemic seemed to touch and alter so many aspects of personal and professional life. This blurring may potentially widen the scope of an interview, where the personal may become

inseparable from the professional, creating different dimensions and expressions of vulnerability and sensitivity for both. Further, as Miller (2017) puts it, the ‘parameters of the interview are much more porous and leaky’ than it may initially seem, as it is not only what happens in the formal interview but also what happens around it that is part of researchers’ and participants’ interactions, engagement and relationship with each other.

For example, Author 2 found that many participants rescheduled interviews due to home-schooling commitments, which expanded the scope of the interview beyond clinical experiences of Covid-19, to corresponding experiences of balancing clinical work with parenting and childcare, worries about their own elderly parents and difficulties seeing them, planning holidays and family events without key members – which resonated with some of the researcher’s own experiences during the pandemic not only as a researcher, but a member of the public. When interviewing the same individual over time, these blurred personal and professional aspects were repeatedly revisited as part of how participants explained and made sense of their pandemic experiences.

Whilst this blurring of boundaries is more often described in immersive research, the pandemic illustrates how this blurring may occur even through remote single and longitudinal interviews. Much attention has been paid to the pros and cons of disclosure from the researcher in order to demonstrate shared experience (Harris, 2015). A researcher sharing a personal experience influences the dynamic of the interview and may facilitate a rapport, but can also create a perception of lack of affinity between a researcher and a participant, for example, if experiences or how they are shared are not aligned.

In our studies, we found that we tried to limit our personal comments and reflections to allow as much time and space for the participant to voice their own experiences. Throughout the research process, we were aware of tensions between multiple levels of the pandemic context and experience: globalised shared experiences of the pandemic, diverse local experiences expressed through digital and news media, and the accounts of the researcher and individual participants themselves. In practice as a researcher, this meant trying to balance keeping up with the local and global news, and reflecting on wider perspectives, but also allowing participant HCPs space to freely express what they were experiencing.

While conducting our studies, we were also struck by the importance of ending interviews in a way that allowed closure for the participant. We were aware that, at times, for example, participants had to quickly get back to clinical work immediately after an interview. As a result, we wanted to allow space for them at the end of the interview to process what they had said, make final remarks and perhaps talk about the study to give them time to ‘cool off’ and ‘debrief’. This preserved time and conversational space was crucial for longitudinal repeat interviews as well, particularly as part of managing the ongoing involvement of HCPs with many limitations on their time. The pervasiveness of COVID-19 – which has affected

social lives, working patterns and what researchers and HCPs work on – makes it difficult to judge where to draw boundaries between being a professional, a member of society and an individual, and how one should therefore engage with these perspectives and tools.

As researchers studying the views and experiences of HCPs working during the pandemic, our multiple roles were particularly brought to the fore. For example, whilst conducting her study, Author 1 was also seeking help from primary care, which was limited nationally. This contrasted the experience of listening to HCPs describing their difficulties of dealing with patients calling for help when they felt it was ‘unnecessary’ during a health emergency. Equally, we were often reminded of the multiple roles of our participants as well, expressed in interviews through how HCPs were dealing with ramifications of the pandemic in their personal lives. For example, some participants revealed that because of (perceived) risk of COVID-19 infection at work, they decided not to see their children or elderly parents, or even move out of their homes. Researchers therefore had to be mindful of these multiple and shifting roles, thus allowing participants to freely express their own views, and for us to ‘receive’ and respond to them.

Key message: We found that the ‘blurred and leaky’ boundaries of conducting interviews with HCPs in a global pandemic foregrounded how building and maintaining rapport and research relationships was an ongoing negotiation, balancing shifting dynamics and perspectives. The manner in which we ended interviews and research relationships were particularly important in this negotiation, as giving space and time outside of the formal interview helped frame and disengage from research. Researchers must attend to and consider how, when and where such relationships are managed, as the pandemic particularly underlines how even when interviewing professionals (including HCPs) about their work, research itself is not contained within only a ‘professional context’ and neither is it restricted exclusively to a particular research encounter.

Interviews as Spaces to Process Experiences

The nature of the COVID-19 pandemic, resource limitations, and high death rates experienced by many countries, has had severe negative effects on HCPs’ wellbeing, demonstrated in multiple studies (e.g. Borges et al., 2020; Greenberg et al., 2020; van Hout et al., 2022; Wanat et al., 2021a). In addition to the stressors in their professional lives, they have also been facing challenges as members of the public, some of which to a greater extent, including: restrictions on seeing other people; disruptions to everyday life; and widespread uncertainty (Rettie and Daniels 2020). Coping strategies at work that they may have previously found useful may therefore have no longer been feasible or sufficient to deal with the demands of their work, or indeed new roles taken on as a part of the COVID-19 pandemic (Wanat, et al. 2021b). Further, everyday

conversations about and support for these demands may have been limited with colleagues, or inappropriate with families.

These aspects may contribute to HCPs using the interview as a space to reflect on negative or traumatic experiences (e.g. Gale, 1992; Hart & Crawford-Wright, 1999), highlighting the role of researcher as ‘listener’ (McClelland, 2017). A systematic review of vulnerable populations involved in research on sensitive topics by Alexander et al. (2018) showed that although participants experienced discomfort, research experiences were overwhelmingly positive (e.g. ‘it was worth it’, ‘even if it hurt, I would do it again’) (e.g. Hutchinson, et al., 1994; Munhall 1991). Indeed, Hutchinson et al. (1994) highlighted seven potential benefits of taking part in an interview, including catharsis, self-acknowledgement, sense of purpose, self-awareness, empowerment, healing and providing a voice.

However, in the case of longitudinal research, researchers should be aware of repeatedly rehashing the same negative experiences with HCPs (Warin, 2011), especially in the context of an ongoing health emergency. Becoming distressed, or HCPs showing strong feelings, during an interview may be unexpected for both participant and researcher, and may pose different challenges. For example, the identity and perception of HCPs as ‘invulnerable professionals’ may be challenged, which may cause embarrassment and breakdown of rapport. Additionally, this may not be aligned with how HCPs are expected and anticipated to behave, and so researchers may be unprepared to manage such tensions.

In our studies, we found that HCPs used interviews, perhaps not consciously or intentionally, to process, reflect and make sense of their experiences. They often commented that they did not realise that they had so much to say, and were surprised at times by their own emotional reactions such as anger, sadness and frustration. Many HCPs expressed that they found it ‘cathartic’ or ‘therapeutic’ to discuss their experiences during the pandemic and reflected that an interview was an opportunity to process what was happening, which they did not often have, thus contributing their self-care.

In this way, interviews may have been seen as potentially part of or contributing to self-care. Whilst participants rarely expressed that they saw interviews as beneficial to their wellbeing initially, after one-off or repeated interviews many participants verbally reflected on the positive impact that they felt it had had on them. They often expressed gratitude in being able to share their experiences with others, as wider social distancing measures, altered rotas and redeployment meant that for many weeks they may have been unable to see their usual friends, colleagues and others both in and outside work. As wider recommendations and local restrictions changed, opportunities to offload fluctuated; some participants expressed that they ‘looked forward’ to interviews in the longitudinal study and some described having trouble sleeping during different periods, and being unable or finding it impractical to access wellbeing support provided by their workplaces when needed, thus highlighting further benefits of

catharsis, acknowledging and sharing their experiences. Some HCPs from primary care also highlighted that they felt that they have been largely ignored by policy makers and wanted their voices to be heard. However, it is equally important to report that one participant in the longitudinal study chose to discontinue their participation in the UK’s second wave due to the additional strain on their time, which they preferred to spend with family, and recalling what they found to be traumatic memories.

We also found that HCPs commented on the skills and coping strategies which they would use in their work prior to the pandemic, and how these strategies were often not feasible given the restrictions of the pandemic (e.g. ‘lockdown’, social distancing, indoor mixing of households). Interviewing a wide range of HCPs over time similarly highlighted that different HCPs have different skillsets, which go beyond clinical skills and practice, and extend to strategies for and feelings of resilience, coping and control. This speaks to the heterogeneous experiences of different HCPs across primary, secondary and tertiary care in the pandemic context, but also beyond it. Although the pandemic has given rise to unprecedented changes and challenges in healthcare provision, these heterogeneous experiences highlight that as researchers we nevertheless cannot assume that all HCPs are equally equipped to manage different kinds of stress and situations that they may experience, routinely or otherwise.

Key message: Many HCPs used the research interview space to process what happened to them and how they felt about it. They can become vulnerable during the interview and experience a range of emotions, which they did not necessarily have an opportunity to process or express in other contexts. This may contribute to their self-care but may also challenge their identity as a HCP, for which researchers must be prepared.

Motivations to Conduct and Participate in Research

The potential benefits and costs of interviews in qualitative research are well documented (e.g. Hutchinson, et al., 1994; Knox & Burkard 2009). For the participant, there may be an opportunity to share their experiences and have their voice heard, or use the interview as an opportunity to process the experience (as discussed in the previous section), or perhaps to try to influence change in relation to the researched topic. However, there may be mismatches between the motivations and intentions of, and what is at stake for, those conducting the research and participating in it (e.g. Orb, et al., 2001; Morrison, et al., 2012). Further, researchers may not always explicitly communicate what they hope the study will achieve or contribute, whilst participants may expect or hope that the research can lead to direct changes and improvements. Given a widespread novel disease such as COVID-19, the imperative to participate in research during a pandemic may be even more keenly felt – especially by those working on the frontline who

witness its impact first-hand. However, during a pandemic, those who are most relevant to recruit as participants may also be the least able to participate given time, resource and wellbeing constraints.

Ongoing involvement in research, such as longitudinal interviews, offers a unique opportunity to capture the ongoing effects and experiences of the pandemic. However, these may also be a significant time-commitment, and may take time away from other important and potentially limited activities in a pandemic, such as self-care. As an incentive for recruitment, the moral obligation to both conduct and participate in research may also then place undue pressure on already busy HCPs to maintain their participation when they might otherwise feel the need to discontinue their involvement.

In our studies, when asked whether they would be happy to do an interview, a number of participants consistently referred to the importance of contributing to pandemic research (and, by extension, pandemic responses), saying that ‘if it’s helping, then that’s fine’. This was even more pronounced in the longitudinal study, when participants agreed to take part in another interview if they felt it was useful to the study, or the wider research and health community working on the COVID-19 pandemic. We found that we had to work hard to reassure participants that they could decide to leave the study at any point, and should not feel obligated to continue if they wished to stop.

As researchers, we often reflected to what extent HCPs felt obliged to participate and continue to participate in (longitudinal) research. Participants also placed an emphasis on wanting to know more about the findings and the impact of the study, especially keen to understand how their input and others’ contributed to understandings of and responses to the pandemic in general. This might link to the powerlessness, uncertainty and lack of control many HCPs may have experienced especially during the early part of the pandemic where evidence was lacking and death rates were high; partaking in research may have given a sense of doing something active and positive with those experiences (Hunt & O’Brien 2009).

Key message: Researchers have a significant responsibility to ensure that research data are analysed and findings disseminated to appropriate audiences, given participants’ commitment; this is a process which participants themselves could be involved in guiding. Taking part in interviews may represent a trade-off for HCPs, potentially offering certain benefits whilst, as noted, also potentially negatively impacting time, other resources and wellbeing. Researchers should be aware of this tension and allow participants’ to consider this trade-off in the context of (each) interview. HCPs’ responses highlight that issues around the ‘usefulness’ of taking part, and for whom, need to be addressed to acknowledge the costs of participating in research during such difficult times as a pandemic. As participants also often expressed that they wanted transparent communication about the aims and impacts of the research, researchers could co-produce these aims

with participants and/or could mobilise specific strategies to follow up on dissemination and impact, and feed this back to participants, if desired.

Discussion

Based on our experiences of conducting interviews with HCPs in the UK and Europe during the global COVID-19 pandemic, we explored arising issues, tensions and considerations related to ‘vulnerability’ and ‘sensitivity.’ We explored these in relation to three core facets that we identified: (i) blurred boundaries in participant-researcher relationships; (ii) interviews as spaces to process experiences; and (iii) motivations to conduct and participate in research.

Overall, our experiences highlighted that, as researchers, we cannot assume that the same expectations about vulnerability and sensitivity that apply to HCPs at work and as professionals should apply to them in qualitative research and interviews. We similarly cannot rely on these assumptions when building rapport, managing research relationships, or conducting effective and ethical research with HCP participants, as this may shut down conversations, erode research relationships and leave researchers unprepared.

Through our joint reflections, we have demonstrated that the categories of ‘vulnerable’ and ‘sensitive’ cannot be applied consistently to mean the same thing over the course of the research process, a research relationship, or a single research encounter. This categorisation overlooks the nuances and complexities which also inform how researchers should practically approach and undertake ethical research. Vulnerability and sensitivity as abstract or absolute/static concepts – away from real-life situations and relationships – may thus be all too easily blinkering. During the course of our research here, we found that these understandings were rather emergent through inter-relationality, sociocultural and other (interactional) processes, in context.

This reframing is echoed by some scholars who have expressed in literature discomfort with the assumptions that seem inherently bound up in uncritical reckonings of ‘vulnerable participants’ and ‘sensitive topics’ (Taket, 2008), and similarly have questioned ‘how far ethical norms and rules can be usefully standardised across research practices and particular contexts of research’. (Mattingly, 2005, p. 469) For example, that making these early judgements, prior to any research encounters, ‘assumes a knowledge [we] do not necessarily have, and hints of arrogance and paternalism.’ (Taket, 2008, p. 196) We have built on these critiques to offer further guidance to researchers specifically undertaking qualitative research with HCPs.

The pandemic thus allows us to question the categories of ‘vulnerability’ and ‘sensitivity’ as applied to research with HCPs, underlining the essential role of context in their reckoning. Similarly, it foregrounds the importance of interrogating the utility, necessity and benefit of research with HCPs during a pandemic, when and for whom. Interviews and

discussions about health and healthcare during the pandemic for both researchers and HCP participants allowed sense-making and reflection that also bolstered feelings of resilience and coping, as reflected in conversations with participants, and researchers' own conversations with each other during and after research.

In order to leverage these benefits, as well as prepare researchers for attendant challenges, we suggest that researchers conducting qualitative research with HCPs critically give thought to the issues discussed on an ongoing basis for each study, though how they emerge will differ from study to study, and participant to participant. We suggest here the following 'solutions' to begin to address the aforementioned issues, which we hope can offer a useful starting platform for researchers

1. We cannot assume that all HCPs have viable coping strategies for the context or situation being researched. Research teams should discuss beforehand how they plan to deal with sensitive topics and discussions that are anticipated, and surprising ones. Researchers are also responsible for considering and ensuring that appropriate and relevant resources (e.g. links mental health helplines) are provided and highlighted to HCPs at the end of the interview. As a minimum, researchers may want to explicitly provide an opportunity to debrief for the participants.
2. Interviews may aid HCPs in processing their experiences but (longitudinal) interviews may also bring up some issues again and again, which can be problematic for HCPs. This requires reflection and open discussion between participant and researcher, to ensure that HCPs can decline (further) interviews or particular questions, if they so wish. The importance of ongoing consent is crucial here (Smith, 1999).
3. While during a pandemic or health emergency there is a need to rapidly answer questions and produce good data, this must be balanced at the level of the individual participant. Clear communication about usefulness, aims and potential impacts of a study and participation should be addressed explicitly (Vindrola-Padros, et al. 2020b) with participants at the beginning of the study as well as throughout, if needed. Equally, researchers should consider how dissemination and impact could be fed back to participants if desired. It is important to allow discussion with participants regarding their perceived costs and benefits of taking part in research, especially if instigated by the participants themselves.
4. Researchers should ensure that HCPs have as much flexibility as possible in deciding the length, timing and location of the interview and/or communication method (e.g. telephone, teleconference and digital platform), taking into considerations institutional and data protection agreements. These should be considered in the context of HCPs' commitments

(Vindrola-Padros, et al. 2020b) and should be highlighted in Participant Information Sheets.

5. Given potential negative implications of lack of debrief, researchers need to enter into the dialogue of closure. This may involve, for example, allocating time after an interview, with a researcher summarising the study aims and advising the participants on the next steps for the study, while also allowing the participants to reflect on their experience of being interviewed. This may be especially important and valuable for longitudinal interview studies. Researchers, research supervisors and human subject ethics committees are urged to establish protocols to guide how research relationships are ended within the context of qualitative methods, with considerations given to the length of research relationships.
6. The blurring of boundaries in shared contexts such as a pandemic forces transcendence of typical roles when conducting research. This highlights the need for researchers to have expertise in, and to feel (personally) comfortable, having difficult conversations in the context of the interview and their own fears or anxieties regarding the pandemic, or other relevant considerations (Liamputtong, 2011). While some of this 'readiness' may be facilitated by gaining more experience, it is also important that the researchers are actively supported and encouraged by their peers and senior colleagues to reflect on their reactions and feelings during an interview.

Conclusions

Vulnerability and sensitivity are dynamic and interacting over time for the same person, and emerge through relationships; that is, it may be very difficult to have an informed understanding of what vulnerability and sensitivity means for an individual participant without having interacted with them. Qualitative interviews during a pandemic are embedded in sense-making processes for both the interviewer and participant, and as such can play an important role in coping and resilience. We therefore argue for ethically active research that critically engages with the concepts of 'vulnerability' and 'sensitivity' in context over time, and underpinning assumptions, as part of the reflexive process, for current and future research with HCPs and other groups beyond pandemic contexts.

Although a researcher may not be researching a 'sensitive topic', it may indeed be a 'sensitive time'; further, vulnerabilities for the HCP may be revealed during an interview, for which the researcher and/or participant may not be prepared. The 'solutions' that we outline above offer a concrete starting point for developing a clear plan that should be in place for managing emerging tensions before, during and after an interview. Actively and dynamically engaging with ethical and methodological issues throughout the research process is

necessary for qualitative health research that safeguards and prepares participants and researchers, whilst at the same time is critically reflexive, pursues meaningful impact and honours participants' contributions and accounts.

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